

## Intramurals Permission Slip

**Event:** Basketball

**Dates:** Tuesdays, December 3rd, 10th, 15th

**Grade:** 3-8

**Time:** 3:00-4:00

**Cost:** \$0

**Location:** School Gymnasium / School Field

Please write your child's FIRST AND LAST name. Cut and return bottom half of this slip to Ms. Judd by the start of the activity.

**Student Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Medical Condition:** \_\_\_\_\_ (see below for details)

**Homeroom Teacher/Grade:** \_\_\_\_\_

I give my permission for my son/daughter to participate in \_\_\_\_\_ after school. In case of accident or illness and a parent is not available, I authorize the school personnel to seek emergency medical care, including transportation to the hospital emergency room. I hereby authorize the physician in charge to administer whatever emergency room treatment is necessary. A physician order must be on file at the school before staff can administer any medication. I give my permission for an administrator designated person to assist my child in taking of his/her medication during the event as necessary.

**Parent Name (printed):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_ My child will go to the after school program when the activity is completed.

Contact Ms. Isham ([sisham@sau15.net](mailto:sisham@sau15.net)) or Ms. Judd ([ajudd@sau15.net](mailto:ajudd@sau15.net)) if you have any questions.