Student Travel Authorization

_____
Name of Trip

_____ has my permission to travel to _____ by
Name of Student Name of City/Conference

_____ for _____ on _____.
Mode of Transportation Purpose of Trip Date

The group will be leaving _____ at _____ and will be
Departure Point Departure Time

returning to _____ at approximately _____.
Point of Departure or Elsewhere Return Time

I agree to hold harmless the Cumberland County Board of Education and its employees, and understand that they are not responsible in case of an accident. If an accident should occur, I grant permission for my child to receive medical care and accept responsibility for payment. By my signature below, I acknowledge and accept the terms and conditions stated above, and I am fully aware of the risks involved. In case of an emergency, please contact _____ at _____.
Parent/Guardian Phone Number

_____ _____
Parent/Guardian's Signature ***Date***

SPECIAL POWER OF ATTORNEY

I, _____, as parent or guardian (circle), residing at _____ do hereby Constitute and
Street City State Zip

appoint the _____, a division of the Cumberland County Board
Name of Organization

of Education, 810 North Main Street, Burkesville, KY 42717, as my Attorney-In-Fact to act as follows, giving and granted to my said Attorney-In-Fact full power to: *Provide any and all information available to qualified medical personnel or hospital staff, and to authorize and execute consent for any and all medical and hospital care and treatment including major surgery, deemed necessary by a duty licensed physician selected by my Attorney-In-Fact for the health and well-being of my following child/children:*

_____

Further, thereby authorize my aforesaid Attorney-In-Fact to perform all necessary acts in the execution of the aforesaid authorization with the same validity and right as I could effect if personally present. Any act or thing unlawfully done thereunder by my said Attorney-In-Fact shall be binding upon me and my heirs, administrators, executors, successors, and assigns.

Further, I hereby agree to hold harmless my said Attorney-In-Fact from any liability claims, charges, or cost related to his/her execution of the aforesaid authorization.

Further, unless sooner revoked by me, this special medical power of attorney shall become null and void from and after the _____ day of _____, 20_____.

_____ _____
Parent/Guardian's Signature ***Date***

CERTIFICATION OF NOTARY

Subscribed and sworn to before me this _____ day of _____, 20____.

Notary Public _____

_____ County, KY

My Commission Expires _____

Review/Revised:8/9/2000