

CONSENT & MEDICAL AUTHORIZATION



SCHOOL: Olathe East High School

ACTIVITY: Annual Theatre Retreat

SCHEDULED DATE: July 22nd – 24th, 2026

Name of Group: OE Theatre/Thespians

Name of Teacher(s)/Sponsor(s): Mr. Edward Shafer

Time of Departure: 11:00am July 22nd Estimated Time of Return: 10:00pm July 24th

Field Trip Origination and Termination Point: Org. – Olathe East High School, Westside Parking Lot
Term. – Olathe East High School, Westside Parking Lot

Location of Field Trip: Hyatt Place – Overland Park
5001 West 110th Street
Overland Park, Kansas 66211
Phone – 913-491-9002

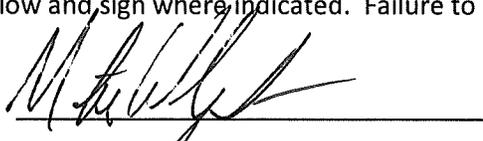
Rationale for Taking This Trip: The Theatre Retreat is a wonderful opportunity for students to learn more about both performance and technical aspects of theatre. Students will be able to see professional musicals and plays, tour performance facilities, attend professional workshops, and work on team building with fellow thespians and OE Theatre members.

_____ has my permission to attend the Theatre Retreat on July 22nd – 24th, 2026. I understand that the activity is a school sponsored event. I understand that if my student must be sent home early for disciplinary reasons, it will be at my expense. The school district representative supervising the activity is hereby granted my permission to seek and authorize any medical treatment that may be necessary for the health and well-being of the above student in the event of accident or injury while he/she is attending the activity listed for which my permission has been given.

Please make one of the boxes listed below and sign where indicated. Failure to return this form will prevent your child from participating in the above activity.



Sponsor



Administrator

03/03/26

Date

Students who consume drugs/tobacco/alcohol, are under the influence of drugs/tobacco/alcohol or are in the possession of drugs/tobacco/alcohol will be returned home at the expense of the parent on the first violation. Parents will be contacted immediately, and the student will be expelled from participation in all OE Theatre related activities in the subsequent season.

Student Signature

Parent Signature

Date

Please complete the Medical Care & Treatment Form on the reverse side.

Consent of Parents/Guardian – Medical Care & Treatment Form

Student Name:		Date of Birth:
Parents' Names:		
Telephone (Home)	(Work)	(Cell)
Home Address:		
City	State	Zip:
Name of Family Doctor:		Telephone:
Address:		
City	State	Zip:
If you or the doctor cannot be notified, in an emergency notify:		
Name:		Telephone:
Address:		
City	State	Zip:
Health Insurance Company		Telephone:
Address		
City	State	Zip:
Policy Number:		Group Number:

Circle any of the following that apply to the student:

Asthma	Allergies	Anaphylaxis	Diabetes	Heart Condition
Seizures	Fainting	Bipolar	Depression	Digestion Issues
Acid Reflux	ADD/ADHD	Hypothyroidism	Hypoglycemia	Migraines
Anxiety	Other:	Other:	Other:	Other:

Please list any prescription medication to be administered on the trip:
