School-Related Student Trip Permission Forms

STUDENT FIELD TRIP PERMISSION SLIP AND MEDICAL RELEASE FORMS

Student's Name _____ _____ _____
Last Name *First Name* *Middle Initial*

Date of Birth _____ School _____ Grade _____ Homeroom/Classroom _____

I hereby give permission for my child to participate in school-related student trip(s) for the _____ school year.

In addition, in the event of accident or sudden illness while on the school-related student trip, I authorize school personnel to contact the physician(s) listed on my child's school enrollment data forms and authorize those physician(s) to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event physician(s), parent(s), or other persons designated by the parent cannot be contacted, school personnel are hereby authorized to take whatever action is deemed necessary in their judgment for the health of said child.

Parent's Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home: Phone: _____ Employer: _____ Work Phone: _____

Insurance Carrier Name & Address: _____

Insurance Policy Number: _____

Emergency Contact (other than parent or guardian): _____Relationship: _____

Address: _____City: _____State: ___ Zip: _____Phone: ____

Family Physician: _____ Phone: _____

Allergies: _____ Last Tetanus: _____

Medical Problems: _____

Medication Being Used on Field Trip (include dosage/frequency): _____

During an overnight/out-of-state trip during the _____ school year, the undersigned hereby grants authority to their child to carry and self-administer over-the-counter medication brought from home. Medication must be provided by the parents or guardians and be in the original container. Please provide only the amount of medication you feel will be necessary to meet your child's needs during the trip.

Please list the over the counter meds that your child may carry and self-administer (elementary schools will require Board Form 09.2241 AP.21): _____

_____

If you do not want your child to be able to carry and administer over the counter medications, please check the following box: ☐

In case of an emergency involving my student and a parent/guardian cannot be contacted, I authorize the use of our family insurance company.

I accept responsibility for notifying the school nurse of any changes in information after this date.

Parent/Guardian Name (Please Print): _____

_____ _____
Parent/Guardian's Signature *Date*

Please return this form to your child's teacher.