

Parent-Guardian Field Trip Consent Form

Student Name _____ School _____

General Information

The _____ is planning a trip to _____.

The purpose of this trip is _____

Trip Destination _____ Phone No. () _____

Address _____ Place of Lodging _____

We will leave from _____ about (time) _____ AM PM

On (date) _____. We will return to the school on (day) _____ (date) _____

At about (time) _____ AM PM Itinerary is attached List of items needed is attached

Type of Transportation

District Vehicle Commercial Transportation District Bus

Other (explain) _____

Medical Information

The following special health problems should be noted and adequate precautions taken (list such items as unusually severe reaction to bee stings, other severe allergies, hemophilia, diabetes, heart disease, etc.)

The following medications, prescriptions or special diets are needed _____

Medical Release

In the event of an accident or illness, I understand that reasonable effort will be made to contact the parent/guardian immediately. However, if I am not available, I authorize school district personnel to secure emergency medical care as needed.

Does your child have Medical Insurance coverage? YES NO

It is recommended that all students have medical or student accident insurance.

Student accident insurance is available through _____ Contact the school for details.

Name of Preferred Doctor _____ Phone No. () _____

Name of Insurance Carrier _____ Policy No. _____

Although I understand that the District will make reasonable effort to provide a safe environment, I am fully aware of the special dangers and risks inherent in participating in a field trip activity. Being fully aware of the risks, I hereby give consent for (Student) _____ to participate in the activity.

Parent/Guardian Name _____ Day Phone () _____

Home Address _____ Evening Phone () _____

Emergency Contact _____ Emergency Phone () _____

Signature of Parent/Guardian _____ Date _____

Parent/Guardian signature reflects their knowledge and approval of the activity described above. This form must be returned to school before the student is involved in the activity.

Permission for Out-of-State Field Trip/Medical Release Form

Permission for Field Trip

Student's Name _____			
Last Name	First Name	Middle Initial	
School _____ Grade _____ Homeroom/Classroom _____			
<i>I give permission for my child to participate in the following school-related student trip and understand that my child is required to follow Board and school policies during this school-sponsored activity.</i>			
Signature of Parent/Guardian's Signature			Date
<u>LIST ALL DESTINATIONS</u>			
Destination	Date	Depart time	Return Time
Destination	Date	Depart time	Return Time
Destination	Date	Depart time	Return Time
Mode of Transportation _____		Cost to Student \$ _____	

Medical Release (Emergency)

<p>In case of emergency, illness or accident to the above named child, while on the school-related student trip, I give consent to the nearest hospital to render medical emergency care deemed appropriate by the hospital staff. I also give consent to school personnel to take whatever action is deemed necessary in their judgement for the health of said child.</p>	
Signature of Parent/Guardian	
Date	

<p>My child <u>HAS</u> the following <u>life-threatening</u> condition that may require <u>EMERGENCY</u> treatment while on a field trip.</p> <p> <input type="checkbox"/> DIABETES <input type="checkbox"/> ASTHMA <input type="checkbox"/> SEIZURES <input type="checkbox"/> SEVERE ALLERGY <input type="checkbox"/> OTHER: _____ </p>

<p>If your child must take any medication while on the field trip, the back side of this form MUST be completed.</p> <p>***RETURN TO TEACHER***</p>

Permission for Out-of-State Field Trip/Medical Release Form

Powell County School Health Program
Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ Date form received: _____

I/we acknowledge receipt of this Health Care Provider's Statement and Parent Authorization.

Student Name: _____ Student age: _____ Date of Birth: _____

Grade: _____ Homeroom/Classroom: _____

TO BE COMPLETED BY PARENT/GUARDIAN

(MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER)

Name of medication: _____ Reason for medication: _____

ALLERGIES: _____ Any OTHER Condition(s): _____

Form of medication/treatment: _____

Tablet/capsule Liquid Inhaler Injection Nebulizer Other _____

Instructions (Schedule and dose to be given at school) _____

Start: Date form received Other, as specified: _____

Stop End of school year Other date/duration: _____

For episodic/emergency events only

Restrictions and/or important side effects: No restrictions

Yes. Please describe: _____

Special storage requirements: None Refrigerate

Other Instructions: _____

Parent or Guardian Signature _____ Date: _____

Health Care Provider Name _____

Address: _____ Phone: _____ FAX: _____

I give permission for (name of child) _____ is to receive the above stated medication at school according to standard School Board policy. I release the School Board and its employees from any claims or liability connected with its reliance on this permission.

By signing below, I understand that I MUST bring / send the medication in its original container.)

Date: _____ Signature: _____ Relationship: _____

Home phone: _____ Work phone: _____ Emergency or CELL phone: _____

Provider MEDICATION AUTHORIZATION

If NO Signature by a health care provider the child will be PROHIBITED from attending the field trip.

This student is capable and responsible to self-administer the above medication:

Yes - Unsupervised Yes-Supervised No

This student may carry this medication: Yes No Any restriction(s): _____

Designated, trained school personnel will assist child with the above named medication if necessary.

Signature: _____ Date _____

Health Care Provider