**PERMISSION FOR FIELD TRIP**

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| / FIELD TRIP PERMISSION SLIP / EMERGENCY FORM | | | |
| Please complete this form that will accompany your child on the field trip. This information is necessary should we need to contact you while we are away from the school. No student will be allowed to participate without this form being completed and signed by the parent or guardian. The information on this form is considered confidential and will accompany the school trip leader/nurse on the trip. | | | |
| Permission is granted for:  [Name] PLEASE PRINT  to take a trip to the [Destination] by [Mode Of Transportation] on [Date]. Time of departure is [Departure Time] and time of return is [Return Time]. | | | |
| PARENT/GUARDIAN INFORMATION: | | | |
| Parent/Guardian Name: [Name] | | | |
| Address: [Address] | | | |
| Phone #: [Phone] | | Emergency Phone #: [Phone] | |
| Please provide the information requested below, as it may be needed in case of an emergency. This information does not modify the information on the emergency card.  Student’s Date of Birth:[Date] | | | |
| Allergies: [Allergies Name] | | | |
| Conditions requiring special consideration (medical/physical):[Condition] | | | |
| Does your student require: (A) **Epipen** Yes □ No □ (B) **Inhaler** Yes □ No □ (C) **ANY MEDICATION CURRENTLY TAKEN:** (Type of medication and time of administration): | | | |
| Please be sure to speak to ’s Nurse before \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Date] regarding any medications or special needs your student may have. THIS INFORMATION WILL REMAIN CONFIDENTIAL. IT WILL STAY WITH THE SCHOOL TRIP LEADER/NURSE ON THE DAY OF THE TRIP. CONTACT INFORMATION FOR DAY OF FIELD TRIP ONLY: | | | |
| Primary contact name: [Name] | | Relationship to student: [Relationship] | |
| Phone #: [Phone] | Work Phone #: [Phone] | | Cell Phone/Pager #: [Phone] |
| Secondary contact name: [Name] | | Relationship to student: [Name] | |
| Phone #: [Phone] | Work Phone #:[Phone] | | Cell Phone/Pager #:[Phone] |
| Student’s Physician: [Name] | | Phone #: [Phone] | |
| Student’s Dentist: [Name] | | Phone #: [Phone] | |
| HEALTH INSURANCE INFORMATION: | | | |
| Company Name: [Name] | Policy #: [Name] | | Group #: [Name] |
| Parent/Guardian Name: [Name] | | | Date: [Date] |
| (PLEASE PRINT) | | | |
| Parent/Guardian Signature: [Signature] | | | |