

**NORWALK PUBLIC SCHOOLS
FIELD TRIP PERMISSION FORM**

School

Student Name: _____ Sex: _____ Grade: _____

Address: _____ Date of Birth: _____

Home Phone: _____ Fax Number _____ Parent E-mail _____

Parent/Legal Guardian: _____ Phone: (____) _____

Business Phone No.: (____) _____ (____) _____ (____) _____

Mother

Father

Guardian

Business Fax No.: (____) _____ (____) _____ (____) _____

Mother

Father

Guardian

Relative or other responsible party: _____

Name

Relationship

Home Phone: (____) _____ Business Telephone: (____) _____ Fax No. (____) _____

My child has permission to participate in the field trip to: _____

I give permission to the group leader in charge to seek urgent and/or emergency medical care for my child. The decision for treatment will be made by the medical provider in consultation with the parent/guardian, if possible. This permission will be used only after efforts to reach a parent/guardian have been made. Furthermore, I agree to waive all claims against the leaders/chaperones of this activity for seeking urgent and/or emergency medical care for my child.

Parent/Guardian Signature

Date

HEALTH INFORMATION (Give dates where known)

Surgery within last year: _____

Is this student under medical treatment at the present time? Yes _____ No _____

If yes, give reason _____

Allergies (food and/or medication) – please list _____

Chronic Health Diagnosis (asthma, diabetes, epilepsy, etc.) _____

Special Health Concerns _____

Emotional Concerns _____

Menstrual Cycle Problems _____

Motion Sickness _____yes _____ no Date of last Tetanus Vaccine _____

Please complete other side

FIELD TRIP INFORMATION FORM

Name of student's medical provider _____

Medical Provider's Phone No. (____) _____ Fax No.(____) _____

Student's Medical Insurance _____

Name of company

Insured adult

Policy No.

Insurance Co. Telephone No. (____) _____

COMPLETE SECTION BELOW IF NECESSARY (MEDICATION INFORMATION

(Provider authorization required if not already on file with school nurse)*

Student Name: _____ Date of Birth: _____

List all medications your child takes (including herbal preparations/vitamins):

* authorization on file must include all required daily doses.

My child may need to take the following medications while on the field trip.

Prescribed medications **must be in the original pharmacy container and include the student's name, prescription number, name of medication, dosage, and directions for administration.** I give permission for school staff to administer the following prescribed medication(s)** to my child

(Name of Student)

** Over the counter medications that have been prescribed by your child's medical provider must be in an unopened container.

<u>Medication</u>	<u>Dosage</u> (How Much)	<u>Frequency</u> (How Often)	<u>Reason Being Given</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent/Guardian Signature

Date