FIELD TRIPS – EXTENDED/OVERNIGHT PERMISSION FORM

INSTRUCTIONS: Complete this form for student participation in extended/overnight field trips. Please note that permission over the phone, via email, or on other written notes are not permissible by Board Policy.

SCHOOL_____ DATE_____

Dear Parent/Guardian:

Your child has the opportunity to participate in the following field trip away from school.

TEACHER_____ GRADE LEVEL/ORGANIZATION_____

TRIP DATE_____ TRIP DESTINATION_____

TRIP PURPOSE_____

_____

TYPE OF TRANSPORTATION_____ LOCATION OF DEPARTURE_____

TIME OF DEPARTURE_____AM/PM APPROXIMATE TIME OF RETURN_____AM/PM

BASIC COST OF TRIP $_____ MONEY DUE BY_____

ADDITIONAL SPENDING MONEY: _____ENCOURAGED

_____WILL NOT BE NECESSARY

LUNCH NEEDED: _____YES _____ NO

If yes, check one of the following: ____will bring from home **or** ____request sack lunch from school.

SCHOOL DISTRICT OF JEFFERSON
OVERNIGHT FIELD TRIP MEDICAL RELEASE FORM

Student's Name:_____
Street Address: _____
City:_____ Zip:_____
Date of Birth:_____

If unable to reach parent/guardian, please notify:
Name:_____
Relationship:_____
Home Phone #:_____
Cell Phone # or Pager:_____

Parent/Guardian Contact: _____
Address:_____
Home Ph #:_____
Work Ph #_____
Cell Ph # or Pager:_____

Medical Insurance Information:
Provider:_____
Contact #:_____
Group #:_____

Student's General Health Information

1. Does your child take medication? YES or NO (**Circle One)**

   A completed and signed *Administering Medication to Students* form is required for each medication (prescription or over-the-counter) to be administered during the field trip.

2. Does your child have any allergies? YES or NO (**Circle One)** If yes, please list: _____

   Does your child require medication to treat severe allergic reactions to insect stings/bites, food, etc? _____

   If yes, a copy of the completed and signed *Food Allergy Action Plan or Administering Medications to Students* forms must accompany this form.

3. Does your child have asthma? YES or NO (**Circle One)**

   If yes, a copy of the student *Asthma Action Plan and Administering Medications to Students* forms must accompany this form.

4. Date of your child's last Tetanus Booster shot: _____

5. Is there any health history that may assist the person in charge if this student should become ill?

   _____

   _____

   Student's Physician: _____

   Address: _____

   City: _____ State: _____ Zip code: _____

Authorization to Treat/Administer Medication: I hereby authorize medical or surgical treatment of _____if any emergency should arise. I give permission for decisions to be made by the certified teacher in charge and/or Jefferson School District representative.

NOTE: Your signature on this form acknowledges your acceptance of financial responsibility for any medical or dental care your child requires.

Signature of Parent/Guardian Date