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| Off-site field trip permission slip | | | |
| /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 a 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 of student) PLEASE PRINT  to take a trip to the **[DESTINATION]** by **[MODE OF TRANSPORT]** on **[DATE] [MONTH] [YEAR]**. Time of departure is **[DEPARTURE TIME]** and time of return is **[RETURN TIME]**. | | | |
| PARENT/GUARDIAN INFORMATION: | | | |
| Parent/Guardian name: | | | |
| Address: | | | |
| Phone number: | | Emergency phone number: | |
| 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 | | | |
| Allergies: | | | |
| Conditions requiring special consideration (medical/physical): | | | |
| 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 make sure that you 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 | | Relationship to student: | |
| Phone number: | Work phone number: | | Mobile number: |
| Secondary contact name | | Relationship to student: | |
| Phone number: | Work phone number: | | Mobile number: |
| Student’s Doctor: | | Phone number: | |
| Student’s Dentist: | | Phone number: | |
| **TO ANY DOCTOR OR HOSPITAL:** I hereby authorise the release of my child’s pertinent medical information to the appropriate professional staff. I give permission to the doctor or hospital to secure treatment for them and to order medications, injections, anaesthesia or surgery for my child, as named above, in case of emergency. The signature below constitutes authorisation to perform any necessary treatment for my child during this field trip. | | | |
| HEALTH INSURANCE INFORMATION: | | | |
| Company name: | Policy number: | | Group number: |
| Parent/Guardian name: | | | Date: |
| (PLEASE PRINT) | | | |
| Parent/Guardian signature: | | | |