ADVISOR: After the parent completes this form send it to the nurse 10 days before the trip. After the medical review the nurse will return the original forms to you.

CLEARVIEW REGIONAL HIGH SCHOOL FIELD TRIP – PARENT PERMISSION

Student _____ Gr. _____ student cell _____
Print

Parent _____
Print

Parent phone number during time of the trip Home #_____ Work # _____ Cell # _____

Destination of Trip _____ Date _____

Depart from school @_____ Return to school approximately _____

Cost of Trip: Transportation _____ Admission _____ Lunch _____ Other _____ Total _____

Medical Condition: Please list medical problems (i.e asthma, seizures, diabetes, etc.) that may impact your child's well being.

_____

_____

_____

Medication: Only the following medications may be taken on the trip i.e., asthma inhalers, diabetic insulin or Epi-pen or Benadryl for food or insect allergies. No other medication will be permitted.

Medication _____ Dose _____ Time _____

Medication _____ Dose _____ Time _____

Physician's Name _____ Phone _____

I grant permission for my child to participate in the field trip, and for his/her medical condition to be shared confidentially with the field trip advisor.

_____ _____

Parent Signature **Date**

_____ _____

Advisor's Signature **Date**

_____ _____

Nurse's Signature **Date**