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.

____

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____

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**