PENNCREST
EMPOWERING LIFE-LONG LEARNERS

Student Travel Permission Form

Student's Name: _____ Grade: ____

Parent/Guardian(s) Name: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Emergency Contact Name: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Doctor's name: _____ Doctor's Phone Number: _____

Does your child have any health problems? Yes ☐ No ☐
If yes, please describe: _____
_____

Does your child need any medication for this event? Yes ☐ No ☐
If yes, please list medication(s) needed: _____
_____

Is a physician's order already on file with the school for this medication? Yes ☐ No ☐

If this information has not been previously submitted, a school medication form must be completed by your physician, including any requests for over-the-counter medicines. The forms may be obtained from the school nurse or downloaded from www.penncrest.org and faxed to the school. Prior to the day of the field trip, please submit only the number of doses needed for the trip to the school nurse in original containers. Any doses of medication remaining after the trip will only be given to parents.

Does your child have any restrictions on activities: Yes ☐ No ☐
If yes, please describe: _____
_____

Allergies: _____

Any other information that would affect participation in this event: _____
_____

DATE OF FIELD TRIP: _____ LOCATION OF FIELD TRIP: _____

For trip permission/medical attention/transportation waiver (boats, trains, busses, etc.), I verify that this information is accurate to the best of my knowledge and grant permission for my child to attend this event or activity and be transported as needed. In the event that I am unable to be reached at the above phone numbers, I grant permission for school staff to obtain emergency treatment for my child and for this information to be provided to medical personnel as described in Sections XII Family Education Rights and Privacy Act (FERPA) and XVIII Health Insurance Portability and Accountability Act of 1996 (HIPAA) in the Student Rights and Responsibilities Handbook.

I fully understand that the responsibility for all make-up work rests with my son/daughter.

Parent's Signature: _____ Date: _____

Complete only for overnight trips:
Health Insurance Provider: _____ Policy Number: _____