## STONINGTON PUBLIC SCHOOLS FIELD TRIP RELEASE AND PERMISSION FORM E

My child	, has my perr	nission to participate in
Nam	e of Child	* *
the school field trip to	on	and
Destination	Date	
returning on	. I understand that the bus will l	eave school at
Date	_	
and return at approx	imately	
Time Leaving	Time Returning	

If the school day is over, it is my responsibility to secure my child's transportation home.

## Placing a check mark in this box indicates parent/guardian interest in a need-based trip scholarship for this student.

I have received a copy of the itinerary. I am aware of the rules and regulations as stated in the student handbook which will be in effect on this trip. I fully understand that, should any of the Trip Coordinator/s determine that my son or daughter has violated any of the rules, I may be required to pick up my child at a mutually agreed upon location. I will be responsible for the payment of any additional transportation fees.

I fully understand that the Stonington Public Schools will not provide accident, medical, hospitalization or any other kind of insurance for students participating in the trip. Should my son or daughter be injured, resulting in the need for medical attention, I understand and hereby agree to be wholly responsible for all medical, hospitalization, transportation and related expenses which may arise as a result of said injury.

In case of accident or serious illness, I request the Trip Coordinator/s to contact me. If he/she is unable to reach me, the Trip Coordinator should then attempt to contact either of the two family members/friends listed. If the Trip Coordinator is unable to contact me or either of the family members/friends listed, the Trip Coordinator should attempt to contact the physician listed on the following page. The Trip Coordinator is authorized to follow this physician's medical instructions. If the Trip Coordinator is unable to contact any of the aforementioned individuals, the Trip Coordinator is authorized to make all necessary medical arrangements, including transportation by ambulance and emergency care by medical personnel if necessary.

I hereby hold the Trip Coordinator/s, the particular Stonington school, the Town of Stonington, and the Stonington Board of Education free and harmless from any and all claims that may arise as a result of the Trip Coordinator/s pursuing and authorizing medical care in the manner provided above. I have read, understand and agree to see the above information on this form.

Parent/Guardian (signature)	Date	Home Phone	Work Phone	
Home Address		Pager/Cell Phone #		
List two local family members or fi	riends who have a	ngreed to care for yo	ur child if you cannot	be reach
1.				
I.    Name (please print)			Relationship	
Home Phone	Work P	hone	Cell Phone/other	
2				
Name (please print)			Relationship	Phone
Home Phone	Work	Phone	Cell Phone/other	
Has daily medication been prescrib If yes, list	ed by your physic	cian? 🗌 YES	NO	
Name of Local Physician	(please prin	t)	Pho	ne
*****	**0PTIONAL.*	****	*****	*
HEALTH INSURANCE - Name of Insurance Company				
ID Number:	Group	Number:		_
Parent/Guardia Please note: Trip Coordinator will 1		nurra at lasst one	Date	_
(elementary and middle schools) pr			lok (iligii School)/two	WEEKS