STUDENT OVER NIGHT TRIP APPLICATION FORM

Name_____Street_____

City_____ State_____ Zip Code_____

Phone# (include area code) _____E-Mail Address_____

Name of the Trip_____ Present Grade Level_____ Team_____

EMERGENCY CONTACT INFORMATION

Please give the name of a parent or guardian who consents to your participation in this trip.

Name_____
Last First
Home Address of Parent or Guardian_____

City_____State_____Zip_____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____

Please provide the name and phone number of an alternate contact that may be used if an emergency arises and we cannot contact the person listed above.

Name: _____ Relationship: _____

Home Phone number: _____ Work Phone Number: _____

Cell Phone Number: _____

MEDICAL QUESTIONNAIRE/MEDICATION(S) LIST

If your child is to take any medication(s) on the trip, you will need to also fill out the Nurse's Medication Form. Please return with the medication(s) in the original container by the specified date.

Student's Name:_____ Date_____
(Please indicate any additional information on next page, **sign and date where indicated**)

1. Is your child presently taking or will be taking any prescription medication(s) during the trip? ( ) yes ( ) no

Please list prescription medications:

MEDICATION	DOSE	TIMES GIVEN	CONDITION BEING TREATED

Does the trip nurse have your permission to give the following as needed:
Tylenol Yes: _____ No: _____ Ibuprofen Yes: _____ No: _____
Mylanta Yes: _____ No: _____

Doctor's name_____ _Doctor's telephone _____
(Please print)

2. Does your child have any allergies? ( ) yes ( ) no
If yes, please describe: _____

_____

3. Does your child require a special diet? ( ) yes ( ) no
If yes, please describe: _____

_____

4. Does your child have any other health or medical conditions that may be impacted through participation on the trip? ( ) yes ( ) no
If yes, please describe:_____

_____

Please note that the school district will make every effort to provide medical services for participants who have a need for it. These efforts will include:

1. Contacting the parent/doctor to determine if required prescription medications can be altered during the time period of the trip.
2. Arranging for medical services to be provided at the host site.
3. Arranging for certified nurse to participate on the trip.

_____ _____ _____
Parent Name (please print) Signature of Parent/Guardian Date

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

I understand that I will be notified in the case of a medical emergency involving my child. However, in the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event my child is injured or becomes ill. I understand that neither the school district nor any of its agents, servants, or employees will be responsible for medical expenses incurred, but that such expenses will be my responsibility as parent/guardian. I agree to notify the school in the event of any health changes that would restrict my child's participation in any of the activities scheduled for the trip.

CONSENT AND CERTIFICATION

I the undersigned, being the parent or legal guardian of the child named herein do hereby consent to the participation of my child in all of the activities scheduled for the trip noted on this application. I agree to the emergency medical treatment provisions noted above.

_____ Name of trip: _____
Name of the Student (please print)

_____ _____ _____
Name of parent/Guardian (please print) Signature of Parent/Guardian Date