NORWALK PUBLIC SCHOOLS

OVERNIGHT & EXTENDED DAY FIELD TRIP

PERMISSION FORM

_____

School

Student Name:_____ Sex: _____ Grade: _____

Address: _____ Date of Birth: _____

Home Phone: _____ Fax Number _____ Parent E-mail _____

Parent/Legal Guardian: _____ Phone: (___)_____

Business Phone: (___)_____ (___)_____ (___)_____

Mother Father Guardian

Cell Phone: (___)_____ (___)_____ (___)_____

Mother Father Guardian

Relative or other responsible party: _____ _____

Name Relationship

Home Phone: (___)_____ Business Phone: (___)_____ Cell Phone: (___)_____

My child has permission to participate in the field trip to: _____

I give permission to the group leader in charge to seek urgent and/or emergency medical care for my child. The decision for treatment will be made by the medical provider in consultation with the parent/guardian, if possible. This permission will be used only after efforts to reach a parent/guardian have been made. Furthermore, I agree to waive all claims against the leaders/chaperones of this activity for seeking urgent and/or emergency medical care for my child.

_____ _____

Parent/Guardian Signature Date

HEALTH INFORMATION (Give dates where known)

To Be Filled Out By Parent/Guardian

Surgery within last year: _____

Is this student under medical treatment at the present time? Yes_____ No _____

If yes, give reason _____

_____

Allergies (food and/or medication) – please list _____

_____

Chronic Health Diagnosis (asthma, diabetes, epilepsy, etc.) _____

_____

Special Health Concerns _____

Emotional Concerns _____

Menstrual Cycle Problems _____

Motion Sickness _____yes _____ no Date of last Tetanus Vaccine _____

Please complete other side

FIELD TRIP INFORMATION FORM

Name of student's medical provider _____

Medical Provider's Phone No. (____)_____ Fax No.(____)_____

Student's Medical Insurance _____ _____ _____

Name of company Insured adult Policy No.

Insurance Co. Telephone No. (____)_____

Complete the section below ***ONLY*** if your child will require medication on the trip.

Connecticut State Law & Regulations 10-12(a) require a written **medication order of an authorized prescriber**, (physician, dentist, APRN or physician's assistant) **AND parent/guardian written authorization** for the nurse, or in the absence of the nurse, a designee to administer a medication. ***Please note that the authorization must include ALL the required daily doses. This includes over the counter medications as well as prescription medications. Over the counter medications that have been prescribed by your child's medical provider must be in an unopened container. Prescription medications must be in the original pharmacy container and include the child's name, prescription number, name of medication, dosage and directions for administration.***

Student Name _____ Date of Birth _____

List ***ALL*** medications your child needs to take on the trip (including vitamins & herbal preparations). ***And Provider Authorization is necessary for each medication listed below. This includes ALL required doses for each medication.***

Medication	Dosage (How Much)	Frequency (How Much)	Reason Being Given

_____ _____

Parent/Guardian Signature Date

8/01; Revised 1/8/02, 7/10/02, 11/26/08, 5/20/10