PUYALLUP SCHOOL DISTRICT
A Tradition of Excellence

FIELD TRIP PERMISSION TO PARTICIPATE
(Day and Overnight Trips)

PLEASE SIGN AND RETURN TO YOUR CHILD'S TEACHER IMMEDIATELY

I hereby give permission for _____ to participate in the
*(student first and last name)*

_____ in _____ on
*(name of field trip)* *(city, state)*

_____ with _____.
*(date{s})* *(Field Trip Lead/School/Org)*

Signature of Parent or Guardian: _____ Date: _____
**NOTE: Siblings of students are not allowed to attend field trips.*

☐ My student will BRING a sack lunch from home.

☐ My student needs to ORDER a sack lunch from school.

☐ I would like to chaperone.* Name _____ Phone # _____

Email _____
**NOTE: All chaperones must be district-approved volunteers. Contact your school office to confirm your volunteer status.*

| To Be Completed by The Teacher | Transportation for this activity will be provided by: |
|---|---|
| Date(s) of Activity: _____ Departure Time: _____ Return Time: _____<br>Teacher's Name: _____<br>Teacher's Email: _____<br>Description of the Activity and Itinerary: _____ | ☐ District Vehicle by District Staff<br>☐ Private Vehicle by District Staff<br>☐ Volunteer / Parents Transporting Students in Private Vehicle (completed volunteer driver checklist on file)<br>☐ No Transportation Provided: Parents Provide Own Transportation<br>☐ Other (walk, metro bus, etc.) Description: |
| | |
| | |
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| | |
| * For overnight trips—Attached is a detailed itinerary, supervision plan, and room assignment. | |

# Student Emergency Information

Parent/Guardian Name: _____

Home Address: _____

Telephone: Home: _____ Work: _____

Student's Healthcare Provider: _____ Phone: _____

Health Insurance Provider: _____ Policy #: _____

List below the name of another person(s) to contact if you cannot be reached in an emergency:

Emergency Contact #1: _____ Phone: _____

Emergency Contact #2: _____ Phone: _____

*In the event of an accident or illness, every effort will be made to contact the parent or guardian immediately. However, if the parent or guardian is not available, the School District will secure emergency medical care as needed.*

**Signature of Parent or Guardian:** _____ **Date:** _____

## Student Health Questionnaire

**Student Name:** _____ **Date of Birth:** _____ **Grade:** _____

**1.** **Does your child have any known allergies?** ☐ YES ☐ NO

If yes, specify allergen(s): _____

Reaction & Treatment: _____

**2.** **Does your child have any food or dietary restrictions?** ☐ YES ☐ NO

If yes, Explain: _____

**3.** **Does your child have any life-threatening health concerns?** ☐ YES ☐ NO

If yes, Specify: _____

**4.** **Does your child have any medical conditions that require accommodation in order to participate in the trip?** ☐ YES ☐ NO

If yes, specify: _____

_____

5. Does your child require ANY prescription medication(s), supplements, and/or over-the-counter medication during the trip *(i.e., ibuprofen, inhaler)*? ☐ YES ☐ NO

If yes, specify: _____

_____

If yes, complete the outlined steps below:

**a.** Obtain a *Physician's Order for Medication at School* form from your child's health care provider.
- Each medication requires a separate medication order form, including over the counter medication.
- A physician's medication order is required for students to self-carry medication.

**b.** Bring the completed *Physician's Order for Medication at School* form AND your child's medication to the school Health Room to be reviewed by the school nurse.
- Medication(s) must be provided by the student's parent or guardian.
- All medication must be unexpired and in a labeled, pharmacy container that matches the doctor order.
- If your child already has medication at school, *check with the School Nurse to determine if the current school medication orders on file are adequate*. If so, your child's medications will be sent to on the overnight trip with a school staff member and administered as directed.

****If the above steps are not completed, your child will not be eligible to receive medication on the trip. If the medication is related to a life-threatening condition, your child will be restricted from participating.***

Medication paperwork & Medication(s) due by _____

## To be Completed by All Parents Guardians

- I understand that it is my responsibility to inform the school if there are changes in my child's health.
- I understand that the above information may be shared with school district staff or supervising volunteers as needed to protect the health and safety of the student and to plan for a safe environment conducive to learning.
- I authorize the Puyallup School District to secure emergency medical care as needed. I understand every effort will be made to contact me to explain the nature of the problem prior to any involved treatment.
- In the event it becomes necessary for the school district staff-in-charge to obtain emergency care for my student, neither s/he nor the district assumes financial liability for expenses incurred because of the accident, injury, illness and/or unforeseen circumstances.
- I acknowledge that this activity entails known and unanticipated risks which could result in physical or emotional injury, paralysis or death, as well as damage to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.
- I have read the attached itinerary (detailing dates, places of lodging, events, etc.) and understand that the school district will make every reasonable effort to provide a safe environment. I am fully aware of the special dangers and risks inherent in participating in these activities, including physical injury, or other consequences arising from these activities. Being fully informed as to these risks, I hereby consent to my child participating in the activities.

Parent /Guardian Signature:_____ Date:_____

Student information will be kept confidential to protect the privacy of the student. It will not be disclosed or shared without consent.