CLINTON CENTRAL SCHOOL DISTRICT
Field Trip Permission and Medical Authorization Form

Student Name: ______________________ **Date of Birth**:__________**Grade**:________
I give permission for my above named child to attend a field trip to:

Location:____

Date(s) &
Time(s):____

(*Circle the parent/guardian and number to be called first*)
Father/Guardian:____

Home Phone: ___________________ **Work Phone:**________________**Cell**
Phone:_______________

Mother/Guardian:____

Home Phone: ___________________**Work Phone:**________________ **Cell**
Phone:______________

Relative/Friend: (*if a parent cannot be reached*)________________________________

Home Phone:____________________**Work Phone:**________________**Cell**
Phone:_______________

Allergies (*including any drug allergies*):
____

____

Medical Concerns or Problems:
____

____

List all Current Medications:
____

____

List Medication(s) to be administered during this field trip:

____

In the event I cannot be reached, I authorize the following Clinton Central School District official(s) ______________________________________, or an appointed chaperone to give permission for medical, dental, health or hospital services if needed.

________________________________   ____________________
Signature of Parent/Guardian   **Date**

Insurance Information:
Insurance Company   ____

Policy Number   ____