

**Marple Newtown School District
Field Trip Permission & Medical Waiver Form**

Date: _____

To: Parent/Guardian: _____

The _____ will be going on a field trip on _____ to _____. The cost of this field trip is _____ to cover _____. Transportation will/will not be provided by the Marple Newtown School District buses. The bus will leave _____ at _____AM/PM and return at approximately _____AM/PM.

If your child has medical needs please read carefully the following:

If your child requires medication, medical equipment or specific medical attention during the hours of the field trip it must be furnished by the parent to the teacher.

The nurse cannot send medication kept in the health room on the field trip. **Students may NOT bring in medication.** Parents/guardians are responsible for giving necessary student medications/equipment directly to the teacher. Medications must be in their original pharmacy bottle with current date, labeled with the child's name, prescription number and name of medication along with correct instructions. All medications will be kept by the teacher or trip leader. Please make certain that the teacher/ trip leader has the medication prior to departure for the field trip. If nursing coverage on this field trip is provided by a volunteer RN or LPN, I give permission for that volunteer to provide nursing care to my child during the trip. I understand the volunteer is providing this service without compensation, and I agree to hold the volunteer harmless for care provided in good faith, except in cases of gross negligence or willful misconduct.

If required medication/equipment is not provided from home, the student will NOT be permitted to attend the trip.

My child, _____ has my permission to attend this field trip to _____ on _____.

_____ No, medication/medical equipment or specific medical attention is needed by my child on this field trip

_____ Yes, medication/medical equipment or specific medical attention is required by my child on this field trip and as parent/guardian I will provide what is needed by my child to the teacher directly.

Name of Medication: _____

Time to be given: _____ Dosage: _____

Reason for medication: _____

Special Instructions (if any): _____

Person(s) permitted to provide medication/medical attention to my child (other than nurse) _____

Signature of Parent/Guardian

Parent/Guardian Phone

Date