TY'RELLE STEPHENS
School Board President

JAVIER MONTAÑEZ, Ed.D.
Superintendent

Providence Public School District
Office of the Superintendent
797 Westminster Street
Providence, RI 02903-4045
tel. 401.456.9211
fax 401. 456.9252
www.providenceschools.org

FIELD TRIP REQUEST FORM
OVERNIGHT/OUT OF STATE TRIP

Name/s of Teacher/Staff Member/s Submitting Form: _____

Date of Application: _____

School: _____

Destination: _____

Days: _____ Dates: _____# Students: _____# Buses: _____

Chaperone list	**Names/Total Number**
Teachers	Type text here
Parents	
Aids- TAs/CNAs (IEP- Staffing required)	
Note any chaperone trained in First Aid and/or medication administration.	

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Students requiring 1:1 or designated support under IEP/ 504: _____students

Assigned TA/CNA names (one per student): _____

Coverage time(s) & setting(s) (bus, activities, meals, overnight): _____

Transportation & rooming (if overnight) reflect required supports (e.g., adjacent or same floor rooms for students + assigned staff etc.): _____

Support staff are included in the Adults Accompanying Trip counts and logistics (transportation, lodging, tickets, per diem, etc.): _____

Contact for on-trip special education concerns: _____/ phone: _____

Sign offs

Case Manager/Special Education/504 Designee: _____ Date: _____

Trip Lead: _____ Date: _____

Principal: _____ Date:_____

Transportation and other travel costs to be paid by: _____School Dept: _____

School Funds: _____Other: _____ Programs: _____

Note* Payments from students is not a funding option. Donations generally may be accepted, but students and families can't be asked to fund trips, but may raise funds or make a non-specific donation.

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Medication Administration Plan (Completed by School Nurse)

Medication	Dose/Time(s)	Storage (locked/carry)	Qualified Administering Adult*	Backup Designee	Physician Contact

* *Qualified Administering Adult* = RN or properly trained/authorized staff per district protocol.

Emergency Medications (e.g., Epinephrine, Rescue Inhaler, Seizure Meds)

Location & access plan during all activities/bus/overnight: _____

Staff trained in recognition/response: _____

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Nurse Verification & Trip Readiness

☐ Medications received/labeled; MAR prepared; dosage schedules align with itinerary
☐ Trained/authorized adult(s) identified for all required times/locations (incl. overnight)
☐ Communication plan in place for missed doses, side effects, or emergencies

Nearest hospital confirmed: _____/ phone _____

Sign-offs

School Nurse (review & training complete): _____ Date: _____

Trip Lead (received MAR & understands plan): _____ Date: _____

Principal: _____ Date: _____

Local Arrangement of Tour:

Carrier:	
Description:	

Description of Activities, including how this trip relates to your class. Explain pre- and post-activities planned to make use of the information gained from the trip. (Attach additional sheet if necessary)

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For Overnight and/or Out of State Field Trips:

COVID positive Cases

If a student tests positive on the trip, the family will pick up COVID-positive children.

If overnight, add a statement regarding quarantine of roommates and positive cases.

Costs

Please include a statement regarding refunds, trip costs, and process for collecting funds.

Other Costs and Incidental Expenses:

Please indicate how incidental or unexpected costs (e.g., meals not included in trip package, replacement of lost items, emergency accommodations, or transportation changes) will be covered.

Source of funds: ☐ School Department ☐ School Funds ☐ Program Funds ☐ Other: _____

Security

Please provide a detailed plan for overnight security and room checks, including who is responsible and the schedule for these room checks.

Selecting and Assigning Rooms

Describe the process for selecting and assigning rooms for overnight stays. Check all that apply:

- No more than 2 students will be assigned to a room. _____
- 3 students are assigned, but are given the opportunity to request a cot. _____
- Policies related to medical, gender identity, behavior, photos, and confidentiality have been reviewed to establish room assignments. (required) _____
- Parents are aware of the number of students and beds per room. (required) _____

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Overnight Field Trip Security and Room Check Plan (School leadership team and trip organizers)

1. **Person(s) Responsible for Overnight Security and Room Checks**

Please list the individual(s) or group responsible for overseeing security and conducting room checks:
7 Please check - rooming assignments incorporate IEP/medical/behavioral needs (including staff proximity when required)

2. **Schedule for Room Checks:**

Please provide the specific times or frequency of room checks during the overnight field trip:

3. **Special Education/ 504/Health Plan supports (Complete with Case Manager & Principal (Additional Notes or Details (if any)**

Include any other relevant information related to security or room checks for the trip:
7 Please check- All participating students' IEPs/504s/Health plans have been reviewed for field trip access needs (incl. travel, activities, rooming, schedules)

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For Day/Overnight Trips

Costs

Please include a statement regarding refunds, trip cost, and the process for collecting funds.

Health and Safety Issues (Section 1)

Completed by School Nurse Only

Indicate the number of students with special health concerns and list any necessary special arrangements. Please do not include the students' names.

Signature of School Nurse:_____

Number of Students: Ex: (2)	Concern: Ex: allergy to nuts	Provision: Ex: self carry epipen

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Health and Safety Issues (Section 2)

Indicate provisions for students on medication.

	Medication	Physician Contact Information	Person to Administer Medication

Name and Phone Number of the nearest Hospital:

List of Students with Safety Plans or 504s:

Medical and Mobility Needs Assurance:
I confirm that the medical, health, and mobility needs of all participating students have been reviewed. Appropriate accommodations (transportation, lodging, accessibility supports, staffing) have been planned and assigned.

Signature: _____Date: _____

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Emergency Illness/Early Return Plan

In the event, a student becomes ill, injured, or otherwise unable to continue on the trip:
- The parent/guardian will be contacted immediately.
- The designated trip lead, in consultation with the school nurse and principal, will determine whether the student requires early return.
- Transportation arrangements for return will be coordinated with the family.
- A qualified adult chaperone will accompany the student if travel without family is required.

Signature of Trip Lead: _____Date: _____

Signature of primary/lead chaperone(s):

- I read the field trip policy, and I understand. I may not release a student to anyone, including their parents until returning to the school, unless I receive permission from the school principal._____

- I read the field trip policy, and I understand. I may not release a student to anyone including their parents until returning to the school, unless I receive permission from the school principal._____(if more than one chaperone)

REMINDERS: Obtain a medical report from the school nurse for all those attending. All consent forms should be in the supervising teacher's possession throughout the trip.

_____
Principal/ Date

_____
Superintendent/Date

_____
Deputy Superintendent/ Date