



**PARENT/GUARDIAN PERMISSION FORM FOR FIELD TRIPS and MEDICAL INFORMATION**

I am in accord with the purposes of and procedures governing the Field trip. I hereby grant permission for my student to participate. I understand that adequate and appropriate supervision will be provided. I recognize, however, that unanticipated situations and problems can arise on any trip, school-sponsored or otherwise, which situations or problems are not reasonably within the control of the supervising teacher(s) or staff (including volunteers). I further agree to release and hold harmless the Fayette County School District Board of Education, their agents, officers, employees and volunteers, from any and all liability, claims, suits, demands, judgments, costs, interest and expense (including attorneys' fees and costs) arising from such activities, including any accident or injury to my student and the costs of medical services.

In the event of an injury requiring medical attention, I hereby grant permission to the supervising teacher(s) or staff (including volunteers) to attend to my student. If the injury warrants further medical attention, I expect every effort will be made to contact me to receive my specific authorization before action is taken. If efforts to contact me are unsuccessful, I grant permission for necessary medical treatment to be given. In addition, I hereby give my permission to the supervising teacher(s) or staff (including volunteers) to take my student to the Physician, Dentist, or to the hospital if an accident or serious illness occurs on the trip and I cannot be located.

In the event that my student must return to school independently for health, accident, failure to conform to rules established by the teacher in charge, etc. I agree to accept full responsibility for and to pay for the cost of medical care, transportation and other incidental expenses. This permission slip also serves as a contract that the student and parent/guardian understand and agree to the guidelines from each teacher as to making up missed assignments.

Please check below IF you student has allergy or sensitivity that needs to be accommodated on this trip:

- Bee Sting     Nuts     Dairy     Latex     Other: \_\_\_\_\_
- Asthma     Diabetes     Seizure Disorder     Heart Condition     Other: \_\_\_\_\_

Medications need to be administered during the trip:  Yes \*\*     No

**\*\* If my student requires medication**, I understand that I am obligated to ensure that the **medication** and the **Medication Authorization Form** are on file **prior** to the trip and I will supply the medication in the original container on the **day of the trip**. For a student to self-administer any medication (prescription or non- prescription) the Self-Administration Form must be completed by their parent/guardian **and** Physician. Please note, school staff is **not** responsible for self-administered medications.

Student's Name: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: (If unable to reach the above): \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_