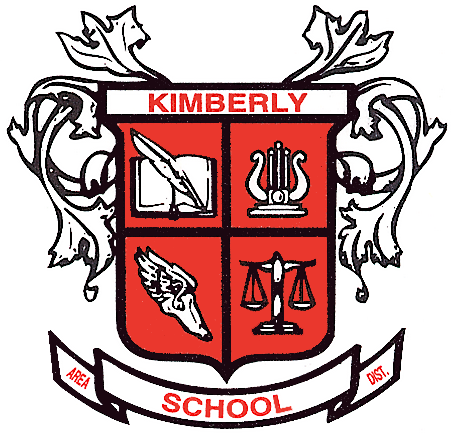
Kimberly Area School District



Grades 5-12

OFF CAMPUS FIELD TRIP PERMISSION

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| NAME OF STUDENT: | | GRADE: |
| DESTINATION: **RUN for ROCKS - JR Gerritts to Sunset Park** | | TEACHER/CLASS: |
| DATE:  **Wednesday, September 13, 2017** | TIME: **3:15 P.M. – 5:00 P.M.** | COST: (make check payable to your school)  **$5.00 run/walk/picnic OR**  **$15.00 run/walk/picnic/t-shirt** |
| ADDITIONAL INFORMATION: (including transportation method) Permission slip due by: **Thursday, September 7, 2017**. Each participant needs their own permission slip/registration form.  *You must be in school and be in good disciplinary standing on the day of the event to attend.  Any requests for exemption must be addressed prior to the event in order to be considered for approval by administration.* | | |

**Emergency contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Does your child have a health condition, including allergies, school staff should be aware of? 🞏 Yes 🞏 No If yes, please explain: |
| Are health forms on file for current school year for conditions listed above? 🞏 Yes 🞏 No |
| List any activities your student is currently restricted from: |
| 1. Medication going to camp/ field trip: 🞏 Yes 🞏 No If you checked YES, Is form on file at your school office: 🞏 Yes 🞏 No  If you checked NO and medication will be going on field trip, you will need a *Request for Giving Medication* Form (located in attendance)  2. Current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please list medication (s) going on fieldtrip:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. Immunizations are up to date:🞏 Yes 🞏 No  4. Is your child prescribed an inhaler: 🞏 Yes 🞏 No \*\* If yes, is form on file at your school office: 🞏 Yes 🞏 No  \*\* If you checked NO and an inhaler will be going, you will need a *Respiratory Care Emergency Plan* form. Please contact the attendance office. |

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| Acetaminophen, Ibuprofen and Benadryl (or generic) are available as stock medication for fieldtrips at the Intermediate (camp only), Middle and High School levels and are offered as a courtesy to students and parents/guardians. Stock medications will only be given as directed on the package.  **Please circle the medications you would like available to your student and the quantity to dispense:**  If nothing is circled, your child will NOT be given stock medications.   |  |  |  | | --- | --- | --- | | **Medication** | **Dose** | **Dose** | | Acetaminophen, 325 mg., each tablet | 1 tablet - 325 mg. | 2 tablets- 650 mg. | | Ibuprofen 200 mg, each tablet | 1 tablet- 200 mg. | 2 tablets- 400 mg. | | Benadryl 25 mg, each tablet | 1 tablet- 25 mg. | 2 tablets- 50 mg. |  * I give permission to designated school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. * I further agree to hold the Kimberly Area School District, and the KASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. |
| Parent Signature: Date: |

**G: District.nurse.readwrite.HealthServicesPPBinder.Fieldtrip Info Revised 04/2016**

**Medical Insurance Information**

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| Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Off Campus Release of Liability**

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| **STUDENT:**  I acknowledge that I assume risks in my choice to participate in the above activity. I also assume full responsibility for my actions. I agree to abide by any and all guidelines established by my school and my instructor.  Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PARENT:**  This is to certify that my student named above has my permission to participate in the activity stated on this permission form. I agree to indemnify, save and hold harmless, the Kimberly Area School District and its employees and officers from liability for any adverse results which may occur.  Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child, named above, in the event of a medical situation occurring during my absence or when hospital or physician(s) are unable to contact me.  This authorization extends to any hospital and both physician and nursing personnel within the hospital as well as any medical authorities and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary for my minor child.  Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**KHS PARENTS ONLY**

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| If District transportation is not provided for this field trip, (see additional information on front side) complete the following section:   * Student can drive only themselves * Student can drive others * Student can ride with others * Student not able to ride or drive with others * Student not able to drive others |

When you pay by check, you expressly authorize this merchant, if your check is dishonored or returned for any reason to electronically debit your account for the amount of the check, plus a processing fee of $25.00. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms.

G:\DISTRICT\nurse\readwrite\Health Services Policy and Procedures Binder\Fieldtrip Info