Field Trip
Parent Consent Form

Student Name: ______________________________________ Student ID No.: ___________

The above named student has my consent to take the field trip described below:

Grade/Class: ___________________________ Date & Time: _________________ Return Time: ___________

Destination of Trip/Activity: ____

Teacher/Staff/Approved Adult Chaperoning: ______________________ Contact Number (optional) ______________

As the student's parent or guardian, I release St. John's Jesuit and any associated person or agency from any claims in consideration for the opportunity for my son to participate in this activity. I understand those transporting St. John's Jesuit students are required to have their own personal liability insurance and are responsible for the care of my son.

Parent/Guardian Signature: ____ Date: ______________________

MEDICAL INFORMATION

Students who have medical conditions that require supplies such as inhalers, epi pens, glucose monitors or snacks for low blood sugars are responsible to bring these supplies on the field trip and alert staff members of such equipment needed.

Allergies (food, insects, medications, others):

____

Do you carry medications for your allergies (list medications and dosages):

____

Current medications (include herbal and over the counter medications as well as prescription medications):

____

____

Pertinent Medical History (Please list medical conditions e.g. diabetes, asthma, seizures, etc. or physical conditions that might be important for emergency care).

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PLEASE COMPLETE EMERGENCY MEDICAL AUTHORIZATON ON REVERSE SIDE.

FIELD TRIP
Emergency Medical Authorization

Emergency Contact Information

Name: ____ Relationship: ______________________

Address: ____

Phone Numbers: Home ___________________ Cell ___________________ Work ___________________

Health Insurance Information:

Company or Organization: ____

Address: ____ Phone Number: _________________

Policy or Contract Number: _________________________________ Expiration Date: ________________

Physician(s)

Primary Care Physician: _____________________________________ Phone Number: ________________

Dentist: ____ Phone Number: ________________

Purpose: *To enable parents to authorize emergency treatment for students who become ill or injured while under school authority, when parents cannot be reached.*

Student Name: ____ Grade: _____

In the event reasonable attempts to contact me at (phone number) _________________________or other parent at (phone number) ____________________, or another authorized person (name and phone number) ____, have been unsuccessful, I hereby give my consent for the administration of any emergency medical treatment deemed necessary and/or the transfer of the student to the nearest hospital.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, conclude on the necessity for such surgery, are obtained before the surgery is performed.

Signature of Parent/Guardian: ____

Date: ____