Classes students will miss while away on field trip:



1 2 3 4 5 6

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Field Trip Request Trip Details Distribution: Health Room School Kitchen Manager

Trip Details									
School: Trip date(s):									
Trip name:						(Add trip o	ode if not us	ing Durham buses)	
Trip type:	rip type: ☐ ASB Activity type: ☐ ATH					(Add trip code if not using Durham buses) Category 1 Category 2 (Out-of-state requires prior approval of the superintendent) Category 3 (Requires school board approval)			
Reason for trip):								
PO number:									
								One-Way Trip	
Departure date	:			Arrive at sch	ool:		ם,	AM □ PM	
SN4.				Depart from	school:			АМ 🗆 РМ	
Return date:				Return to sch	ool:		0,	AM □ PM	
Destination:		440000000000000000000000000000000000000				7			
Arrival date:				Arrive at des	ve at destination:			АМ □РМ	
Departure date	:			Depart from	Depart from destination:				
				Return to sch	rn to school:				
Additional des	tinations:								
☐ District bus	☐ District v	ehicle (T2)		cial transportation		Charter bus* (C	H)		
☐ No district tra		ames in notes)		e: Airline; shuttle				er company name)	
Number	Adults	Students	Wheelchair	n School Bell (C		Other:al accommodation			
of:				1*			(110 (110 0010	w or m notes)	
Contact name:					Conta	ct phone:			
Notes:	(Trip c	oordinating staff n	nember)		001111				
inotes:									
Bus with storag	ge required:	□ Yes □	No						
Substitute Rec	•								
Employe	e name	Subs	titute name	Star	t date	End date		me needed	
								□ AM □ PM	
								□ AM □ PM	
			7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7		W 25 10 10 10 10 10 10 10 10 10 10 10 10 10	es Philipping on Exact Control		□ AM □ PM	
1	Approval fo	or Out-of-Sta	ite			Approval for	Charter I	Bus	
Su	perintendent		Date		Trai	sportation Supe	rvisor	Date	

^{*}The number of buses will be assigned by Durham based on number of riders and needs.

IMPORTANT!

This form is due back to your teacher/advisor NO LATER than

2:15 p.m. on ___/__/___

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Field Trip Informed Consent Notice

Trip name		Trip date	e(s)	Student name			
Reason for trip:							
Trip coordinating staff:			_				
Coordinating staff m	ember signature	Date	Buildi	ng administrator signature	Date		
Destination:			Place of lodging:				
Origin:							
Departure date:					Number of:		
					Adults:		
Departure time:		Arrival time	:		Students:		
Return date:	_	Departure da	ate:		A completed field trip		
Return time:		Departure tii	me:	□ AM □ PM	description and itinerary form MUST be provided.		
Type of transportation							
☐ District bus	☐ District vehicle		☐ Commercial tran	sportation	bus		
☐ No district transportation p	rovided (parent/guardian arrang	ged transportati	ion) 🗖 Other				
	ECTION TO BE CO						
	ent ID number			Student name			
Medical Information				Student name			
Medical Information ☐ My student does not have a	any special health problems.						
Medical Information ☐ My student does not have a List any special health problem	any special health problems. is. The following special health	problems shou	ild be noted and adec		ich items as unusually		
Medical Information ☐ My student does not have a List any special health problem	any special health problems.	problems shou a, diabetes, hea	ald be noted and adeart disease, etc.)		ich items as unusually		
Medical Information ☐ My student does not have a List any special health problem severe reaction to bee stings, of	any special health problems. is. The following special health ther severe allergies, hemophili	a, diabetes, hea	rt disease, etc.)	quate precautions taken (list su			
Medical Information My student does not have a List any special health problem severe reaction to bee stings, of	any special health problems. Is. The following special health ther severe allergies, hemophili r non-prescription, must have s	a, diabetes, hea	ort disease, etc.) om a licensed health	quate precautions taken (list su			
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Revised: May 2018
Revised: August 2018

IMPORTANT!

This form is due back to your teacher/advisor **NO LATER** than

2:15 p.m. on ___/__/___

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Field Trip Informed Consent Notice Adult Supervisor

Trip name		Trip date(s)	a construction of the cons		
Reason for trip:					
Trip coordinating staff:					
Coordinating staff memb	er signature	Date	Building admini	strator signature	Date
Destination:		Na	me of lodging:		
Lodging address:			Iging phone:		
Origin:		Destination:			Number of:
Departure date:					Adults:
Departure time:					Students:
Return date:					A completed field tri
Return time:					description and itinerary form MUST be provided.
Type of transportation					
☐ District bus	☐ District vehicle		Commercial transportation	☐ Charter	r bus
☐ No district transportation provide	ied (parent/guardian arran	ged transportation)	☐ Other:		
SECT	TON TO BE CO	MPLETED	BY ADULT SUP	PERVISOR	
			District staff member		
Adult supe	ervisor name		District staff member		
Medical Information			Ppolitic		
 I do not have any special health 	problems.				
List any special health problems. The	ne following special health	problems should b	e noted and adequate precar	utions taken (list s	uch items as unusually
severe reaction to bee stings, other s	severe altergies, nemophili	a, diabetes, neart di	isease, etc.)		
l am not taking any medications	or topical(s) on this field	trip.			
I am taking the following medica		-			
Name of medication:		1			
Name of prescribing health care pro			me of medication:		
Medical Release	ovider:		Phone numb	oer:	
Medical Release In the event of an accident or illness	ovider:s that is life threatening, I a	authorize the school	Phone numb	ey medical care as	needed.
Medical Release In the event of an accident or illness Name of primary care doctor	ovider:s that is life threatening, I a	authorize the school	Phone numb	ey medical care as	needed.
Medical Release In the event of an accident or illness Name of primary care doctor Primary care doctor's clinic	ovider:s that is life threatening, I a	uthorize the school	Phone numb	eer:ey medical care as	needed.
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Field Trip Category 2 and 3 Overnight, Out-of-State and International Travel Report

This form must be submitted for all overnight, out-of-state and international field trips. For overnight trips, submit this form to the regional deputy/assistant superintendent's office at least forty-five (35) school days prior to the trip. Out-of-state travel (including Victoria and Vancouver BC area) requires prior approval of the superintendent. Submit this form to the regional deputy/assistant superintendent's office (to be provided to the superintendent) at least forty-five (45) school days prior to the trip. International travel requires school board approval. This form must be submitted to the regional deputy/assistant superintendent's office at least one-year prior. In all cases, use the supplemental form on the reverse side to explain special events; fundraising activities; meal and housing provision; any benefits to adult supervisors beyond transportation, lodging, and food; and other pertinent information including lodging and emergency contact numbers for staff members.

		PLETED FOR JTY/ASSISTA					ONAL	
School	Trip dates		Trip coordinating staff (PLEASE PRINT)					
Trip name		Number of s	students	Destination				
Reason for trip: _								
Departure:			I □ РМ	Return:				
	Date	Time	PM		Date	e	Tin	□ AM □ PM ne
Number of adult s	supervisors	Teachers	6			Staf	f member in c	horge
		reactions	b)			Star	i member m c	narge
		Parents/g	guardians			-		
Type of transporta	tion							
☐ District bus		rict vehicle		□ Comm	ercial trans	ortation	☐ Charter	bus
☐ No district trans	portation provided	☐ Operation	ı School			☐ Other		
	•	FINA	ANCIAI	L PLAN				-
No funds that have been	or are to be deposited							
EXPENSES	TOTAL (ticipant = Total Cost	TO	TAL COS'	T TO BE I OM:	PAID	TOTAL	COMMENTS
	(e.g. 13 x \$5	= \$65)	ASB	General	Other Fund	Individual		
Student Transportation	x \$	=	Fund	Fund		Students		
Student Housing	x \$	=						
Student Meals	x \$	=						
Student Other (Registration, etc.)	x \$	=						
Staff Transportation	x \$	=						
Staff per diem	x \$							
(Food & Lodging) Staff Other	x\$							
(Registration, etc.) Release Time Substitutes								
TOTAL	x \$	=		_				
APPROVAL(S): (Pi	rincipal of each part EM/CTE budget re	icipating school quires prior app	l must si proval. P	gn.) Please conta	ect that offi	ce for bu	dget code.	
Principal			Date	ASB Student Representative		Date		
STEM/CTE	Budget Authority		Date	ASB Advisor		Date		
Non School Budget Authority			Date		ASB	Treasure	er	Date



Field Trip Category 2 and 3 Overnight, Out-of-State and International Travel Report Required Supplementary Information

Use this area to explain special events; fundraising activities; meal and housing provisions; any benefits to adult supervisors beyond transportation lodging and food; and other pertinent information including lodging and emergency contact numbers for coordinating staff members.

School	Date of trip	Destination
Field Trip Description and It	inerary	
Along with the Informed Conse	ent Notice, parents/guardians must be p	rovided with a completed field trip description and itinerary form.
Special Events (parades, conc	erts, etc.)	
Fundraising Activities (If non	e, please indicate that no student will be	e denied participation due to lack of funds.)
Meal and Housing Provisions		
Tem and Housing 110visions		
Benefits to Adult Supervisors	beyond Transportation, Lodging and	d Food
Other Pertinent Information overnight trips.)	(Include all telephone numbers at which	h you can be reached during the trip. This is especially important for
Lodging information:		
Name:		
Address:		
Phone:		
Emergency Phone Number of	Coordinating Staff Member(s):	
Name:		Phone:
Name:		Phone:
Name:		Phone:



Field Trip Description and Itinerary Form

Who: (Group/class)
What: (Event/trip)
When: (Departure date/return date)
Where: (Name/address of destination/lodging)
Why: (Purpose/goals/objectives)
Cost:
Transportation:
What to wear: (Clothing requirements)
What to bring: (Include special equipment or supplies)
Food: (Meal plan/arrangements)
Potential hazards/special requirements:
Coordinating staff member(s) contact phone:



Itinerary (include details/major events/planned stops)

Day

Date

Est. times

Activities

Day

Date

Day

Date





SAMPLE

Who: Sample High School Choir

What: State Music Competition

When: July 23-5, 2018

Where: Central Washington University (CWU), 400 E. University Way, Ellensburg, 98296

Motel 6, 403 W. University Way, Ellensburg, 98296 (509) 962-5585

Why: Sample High School choir students compete in the state music competition.

Cost: \$80.00 per student plus meals

Transportation: District bus to and from Ellensburg; students walking from motel to university

campus and back.

What to wear: Black dress/suit for competition; school/weather appropriate clothing for down time.

What to bring: Bring suitcase to school day before trip. Bring money for all meals.

Food: Students need money for ALL meals (see itinerary for meal locations).

Potential hazards/special requirements: Weather will be HOT! Water/drinks to stay hydrated and sunscreen is recommended.

Coordinating staff member(s) contact phone:

John Smith – 425-123-4567 Jane Doe – 206-765-4321



SAMPLE

Itinerary

Monday	July 23, 2018
2:10 p.m.	Meet in Sample HS choir room/load bus
2:30 p.m.	Depart for Ellensburg
4:45 p.m.	Arrive in Ellensburg
5:00 p.m.	Dinner at Brooklyn's Pizza
6:30 p.m.	Check into motel
7:30 p.m.	Attend evening concert at CWU campus
9:30 p.m.	Return to motel
10:00 p.m.	Lights out
Tuesday	July 24, 2018
7:00 a.m.	Rise and shine
8:00 a.m.	Walk to CWU campus for breakfast
9:00 a.m.	All day performances (students break for lunch between performances)
6:00 p.m.	Dinner on CWU campus
7:00 p.m.	Return to motel
10:00 p.m.	Lights out
Wednesday	July 25, 2018
7:00 a.m.	Rise and shine
8:00 a.m.	Walk to CWU campus for breakfast
9:00 a.m.	All day performances (students break for lunch between performances)
5:00 p.m.	Dinner on CWU campus
6:00 p.m.	Awards ceremony
7:00 p.m.	Load bus for return to Sample HS
9:45 p.m.	Estimated return to Sample HS

2/27/07

Request for P.O.

REQUEST FOR ASB PURCHASE ORDER

PO#
PR#
ASB Sec

Present this completed form to the School ASB Secretary.

ACTIVITY / CLUB / SPORT		
ADVISOR / COACH'S NAME		
PURCHASE ORDER FOR (description of items/services to be purchased)		
PURCHASE TO BE LIMITED TO \$ (maximum dollar amount)		
ASB Accounting Code		
Date(s) of Activity		
PAYABLE TO (vendor/company/contractor)	······································	
ADDRESS	~	
CITY AND STATE		
ZIP CODE		
Phone / FAX #		
OTHER NOTES:		
After items/services have been purchased, please return receipts to the ASB Secretary with the PO# clearly written on them.	s, invoices), packing slips,	etc.
Please obtain the following signatures in the order listed:		
Student Rep Name (Signature)	(Printed)	Date
Advisor Signature	Date	
ASB Secretary	Date	
Administrator Signature		



INSTRUCTIONS:

Type or print in ink.
 Submit signed original Travel Request to Accounting <u>at least</u> <u>ten working days</u> in advance of travel or registration deadline.
 All signatories should retain a copy for their records.

4. ESTIMATES ARE REQUIRED FOR ALL REIMBURSABLE EXPENSES

ASB Travel Request

Name:	School	ol/Dept/Position:			
Destination:		Purpose:			
DURATION OF TRAVEL STATUS Begin Travel Status: Date: End Travel Status: Date: Special Circumstances:		Time:			
REGISTRATION EXPENSE: (Check One To be Paid by District in Advance (re To be Paid by Traveler and Submittee TO	egistration form a ed for Reimburser			P-Card	
TRAVEL EXPENSE: (Refer to Business I LODGING: Number of Nights 1 Appr	nformation Ma coved Maximum p				
TRANSPORTATION:	Air Train	n _ _ Bus	\$		
	Rental Car		\$		
	Taxi/Limousine,	/Shuttle	1		
	Personal Vehicle	(Estimate Mileage & P	arking) \$		
	Other: (Describe	e)	<u> </u>		
	TOTAL T	TRANSPORTATI			
MEAL ALLOCATION: Note: Travel status must begin three (3) hours prior provided as part of registration expense, traveler she Total Day Meal Per Diem & Incidentals In-State = \$64 Out-of-State = \$69	to a meal to establi ould adjust their Sta Breakfast In-State \$15 Out-of-State \$16	ish eligibility for entitle atement of Travel Exper Lunch In-State \$18 Out-of-State \$19	ment to such meal. If anses accordingly. Dinner In-State \$31 Out-of State \$34	Total For Day(s)	
First Day/Single Day (1x)				\$0.00	
Days 2 thru $1 (x)$ Final Day $(1x)$				\$ 0.00	
I'mai Day (IX)	***	TOTAL MEAL ALLOCATION			
		TOTAL TRAVE		\$ 0.00	
		TOTAL TRIP E	=	\$ 0.00 \$ 0.00	
Account Code				Ψ 0.00	
SUBSTITUTE REQUIRED: (Check One)	No ☐ Ye	s Dat	e(s)		
APPROVAL			ecord of Payments Accounting Use Only)		
Employee Signature	Date	Date Reference #	Description	Amount	
Student Activity Representative	Date				
Activity Advisor	Date				
ASB Treasurer	Date				
Primary Advisor	Date				
Superintendent's Signature	Date				



INSTRUCTIONS:

Type or print in ink.
 Submit signed original Travel Request to Accounting <u>at least</u> <u>ten working days</u> in advance of travel or registration deadline.
 All signatories should retain a copy for their records.

4. ESTIMATES ARE REQUIRED FOR ALL REIMBURSABLE EXPENSES

Travel Request

Name:	School	/Dept/Position:				
Destination:	Purpos	e:				
DURATION OF TRAVEL STATUS Begin Travel Status: Date: End Travel Status: Date: Special Circumstances:		Time:				
REGISTRATION EXPENSE: (Check On To be Paid by District in Advance (To be Paid by Traveler and Submit To	registration form att	ent.		P-Card		
TRAVEL EXPENSE: (Refer to Business LODGING: Number of Nights 1 App	proved Maximum pe		•)		
TRANSPORTATION:	Air Train _	Bus _	\$			
	Rental Car		\$			
	Taxi/Limousine/S					
		Estimate Mileage & P	,	\$		
	Other: (Describe) TOTAL TE	Other: (Describe)				
MEAL ALLOCATION: Note: Travel status must begin three (3) hours priprovided as part of registration expense, traveler status must begin three (3) hours priprovided as part of registration expense, traveler status provided as part of registration expense, traveler status provided as part of registration expense, traveler status provided as part of registration expense.	or to a meal to establisl	eligibility for entitle	ment to such meal. If			
In-State = \$64 Out-of-State = \$69	In-State \$15 Out-of-State \$16	In-State \$18 Out-of-State \$19	In-State \$31 Out-of State \$34	Total For Day(s)		
First Day/Single Day (1x) Days 2 thru 1 (x)				\$0.00		
Final Day (1x)				\$0.00		
		TOTAL MEAL	ALLOCATION	\$ 0.00		
		TOTAL TRAV	EL EXPENSE	\$ 0.00		
		TOTAL TRIP H	YDENCE	\$ 0.00		
SUBSTITUTE REQUIRED: (Check One	e) No 🗌 Yes		e(s)			
APPROVAL						
			ecord of Payments Accounting Use Only)			
Employee Signature	Date	Date Reference #	Description	Amount		
Supervisor Signature	Date					
Code:	- <u>\$</u> \$					
couc.	Ψ	***************************************				
Budget Authority Signature	Date —					
Superintendent's	Date					