



Field Trip Informed Consent Notice

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Field Trip Title		Student Name	
<hr/>		<hr/>	
Coordinating Staff Member Signature	Date	Building Administrator/Designee Signature	Date
<hr/>		<hr/>	
Destination: _____		Place of Lodging: _____	
Address: _____		Phone #: _____	
Trip Purpose/Objectives: _____			
Class/Staff Member: _____			
<hr/>		<hr/>	
<u>Departure</u>		<u>Return</u>	
<hr/>		<hr/>	
Date: _____		Date: _____	
Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
Location: _____		Location: _____	
		Students _____ Adults _____	
		Itinerary attached: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Item list attached: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Type of Transportation</u>			
<input type="checkbox"/> District Bus <input type="checkbox"/> District Vehicle <input type="checkbox"/> Commercial Transportation <input type="checkbox"/> Other: _____			
<input type="checkbox"/> No District Transportation Provided (parent/guardian arranged transportation)			

SECTION TO BE COMPLETED BY PARENT/GUARDIAN

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Student ID Number		Student Name	
<hr/>		<hr/>	
<u>Medical Information</u>			
<input type="checkbox"/> My student does not have any special health problems.			
List any special health problems. The following special health problems should be noted and adequate precautions taken (list such items as unusually severe reaction to bee stings, other severe allergies, hemophilia, diabetes, heart disease, etc.)			
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Any medication, prescription or non-prescription, must have signed orders from a licensed health care professional and parent/guardian.			
My student <input type="checkbox"/> is not taking any medications or topical(s) on this field trip.			
My student <input type="checkbox"/> is taking the following medication(s) or topical(s) on this field trip.			
Name of medication _____		Name of medication: _____	
Name of Prescribing Health Care Provider: _____		Phone number: _____	
<u>Medical Release</u>			
In the event of an accident or illness, I understand that reasonable effort will be made to contact the student's parent/guardian immediately. However, if they are not available, I authorize the school district to secure emergency medical care as needed.			
Name of Primary Care Doctor _____		Phone No. _____	
Primary Care Doctors Clinic _____		Clinic Phone No. _____	
Name of Insurance Carrier _____		Policy No. _____	
This activity provides a learning experience for the students and allows them an opportunity to apply their classroom learning. Although I understand that the school district will make reasonable effort to provide a safe environment, I am fully aware of the special dangers and risks inherent in participating in the activity. Being fully aware of the risks, I hereby give consent for my student to participate in the activity. My signature reflects my knowledge of the details of the trip and the itinerary.			
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Signature of Parent/Guardian		Date _____ Emergency No: _____	
Parent/Guardian Name _____		Home Phone No. _____	
Home Address _____		Work Phone No. _____	
		Cell Phone No. _____	
Please return this form to _____ before (date) _____ and keep any attachment for your information.			