

**NORWALK PUBLIC SCHOOLS  
OVERNIGHT & EXTENDED DAY FIELD TRIP  
PERMISSION FORM**

\_\_\_\_\_ **School** \_\_\_\_\_

Student Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Fax Number \_\_\_\_\_ Parent E-mail \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Mother

Father

Guardian

Cell Phone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Mother

Father

Guardian

Relative or other responsible party: \_\_\_\_\_

Name

Relationship

Home Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

My child has permission to participate in the field trip to: \_\_\_\_\_

I give permission to the group leader in charge to seek urgent and/or emergency medical care for my child. The decision for treatment will be made by the medical provider in consultation with the parent/guardian, if possible. This permission will be used only after efforts to reach a parent/guardian have been made. Furthermore, I agree to waive all claims against the leaders/chaperones of this activity for seeking urgent and/or emergency medical care for my child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**HEALTH INFORMATION (Give dates where known)**  
To Be Filled Out By Parent/Guardian

Surgery within last year: \_\_\_\_\_

Is this student under medical treatment at the present time? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give reason \_\_\_\_\_

Allergies (food and/or medication) – please list \_\_\_\_\_

Chronic Health Diagnosis (asthma, diabetes, epilepsy, etc.) \_\_\_\_\_

Special Health Concerns \_\_\_\_\_

Emotional Concerns \_\_\_\_\_

Menstrual Cycle Problems \_\_\_\_\_

Motion Sickness \_\_\_\_\_ yes \_\_\_\_\_ no Date of last Tetanus Vaccine \_\_\_\_\_

**Please complete other side**

FIELD TRIP INFORMATION FORM

Name of student's medical provider \_\_\_\_\_

Medical Provider's Phone No. (\_\_\_\_) \_\_\_\_\_ Fax No.(\_\_\_\_) \_\_\_\_\_

Student's Medical Insurance \_\_\_\_\_

Name of company Insured adult Policy No.

Insurance Co. Telephone No. (\_\_\_\_) \_\_\_\_\_

Complete the section below **ONLY** if your child will require medication on the trip.

Connecticut State Law & Regulations 10-12(a) require a written **medication order of an authorized prescriber**, (physician, dentist, APRN or physician's assistant) **AND parent/guardian written authorization** for the nurse, or in the absence of the nurse, a designee to administer a medication. **Please note that the authorization must include ALL the required daily doses. This includes over the counter medications as well as prescription medications. Over the counter medications that have been prescribed by your child's medical provider must be in an unopened container. Prescription medications must be in the original pharmacy container and include the child's name, prescription number, name of medication, dosage and directions for administration.**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

List **ALL** medications your child needs to take on the trip (including vitamins & herbal preparations). **And Provider Authorization is necessary for each medication listed below. This includes ALL required doses for each medication.**

<u>Medication</u>	<u>Dosage</u> (How Much)	<u>Frequency</u> (How Much)	<u>Reason Being Given</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent/Guardian Signature

Date