CENTRAL VALLEY
SCHOOL DISTRICT #356

Parent/Guardian Instructional Field Trip Permission Form

Name of Student (Please print) _____ Teacher _____ Grade 4th Name of Parent/Guardian (Please print) _____

I, the undersigned parent or guardian of the above named student, give my permission for my student to participate in the instructional field trip described as follows:

Date of trip May 8, 2019 Approximate time leaving 9:30 Approximate time returning 12:30

Destination and activities Martin Woldson Theater at the Fox Spokane Symphony Concert Teacher/Advisor Mrs. Schultz

Transportation by ☑ School Bus ❑ Walking ❑ Other (Specify) _____

Emergency Medical Information and Authorization:

Student's Name _____ **Home Phone** _____ **Cell** _____

Father/Guardian/Custodian Name (Circle one) _____ **Home Phone** _____ **Work** _____ **Cell** _____

Mother/Guardian/Custodian Name (Circle one) _____ **Home Phone** _____ **Work** _____ **Cell** _____

Doctor's Name _____ **Phone** _____

Dentist's Name _____ **Phone** _____

Name of person to notify if parent/guardian/custodian can't be reached _____ Phone _____

Permission to treat if necessary: ❑ Yes ❑ No

Permission to transport to nearest medical facility if unable to reach parent/guardian/custodian: ❑ Yes ❑ No

To: Emergency Medical Personnel:

I, the undersigned parent/guardian/custodian of _____
Student's name

a minor, authorize accompanying school personnel to consent in any emergency situation to any xray examination, laboratory test, anesthetic, medical or surgical procedure or hospital care required on the above minor while in their custody, and for which I am unable to be reached to provide consent. Such care must be recommended by and performed under the supervision of a physician licensed to practice medicine in the United States. I understand that if transportation by ambulance is necessary, I must assume the financial responsibility. My student may be released to accompanying school personnel following completion of treatment and in my absence.

Please list any allergies your student may have, any medications being taken, special health problems we should know to assist in your student's safety. (ie Heart condition, hemophilia, diabetes, asthma, other)

Allergies: _____ **Medications**: _____

Other considerations: _____

Current physician and parent permission forms for Administration of Medication at School must be obtained if medication is not routinely being given at school. I understand the district does not provide medical insurance for my student for purposes of this trip, and I am solely responsible for providing insurance and for payment of any medical treatment expenses for my student that are not covered by insurance. I have read the foregoing information, verify its accuracy, and agree to the statements made above.

X _____ _____
Parent/Guardian Signature **Date signed**

	First Period	Second Period	Third Period	Fourth Period	Fifth Period	Sixth Period	Advisor
Teacher's Initials							

White: To be filed with principal/designee prior to departure of trip(s)
Yellow: Teacher/Coach/Advisor

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Revised 6/2011