Field Trip Permission Form

Please complete this form that will accompany your child on the field trip. This information is necessary in case we need to contact you while your child/children are away on the field trip. In your absence, this consent authorizes medical treatment of your minor child. This authorization covers the times when your child is involved in Athletics, Camporee's, Olympics, Adventist Youth Society, Pathfinder/Adventurer, Little Lamb, Eager Beaver or Youth Federations, Youth Congress, Youth Camp or any activities related to the following. Further it releases Allegheny West Conference from responsibility for any and all personal injury or damage incurred while traveling to or from, or participating in any Athletic, Olympic, Adventist Youth Society, Pathfinder/Adventurer Event or Field Trip, Youth Federation, Youth Camp or Youth Congress activities or Youth Event sponsored by the Allegheny West Conference of Seventh-day Adventist. No youth will be allowed to participate without this form being completed and signed by the parent or guardian. The information on this form is considered confidential, a copy is submitted to the Youth Ministries office and will accompany the field trip leader on the trip.

Permission is granted for:

(Name of Student) PLEASE PRINT

to take a trip to the **Rescue Cleveland Southeast SDA Church, 16602, Tarkington Ave. Cleveland, Ohio, 44128** /Traveling by: **Car** on this date and time: **Sunday, July 12, 10:00am.** And will return on this date and time: **Sunday, July 19, 10:00am.**

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name:

Address:

Phone #: Emergency Phone #:

Please provide the information requested below, as it may be needed in case of emergency.
Student's Date of Birth

Allergies:

Conditions requiring special consideration (medical/physical):

Does your student require: (A) **Epipen** Yes ☐ No ☐ (B) **Inhaler** Yes ☐ No ☐ (C) **ANY MEDICATION CURRENTLY TAKEN:** (Type of medication and time of administration):

Please be sure to speak to a nurse or medical personnel before the field trip: _____ **[DATE]** regarding any medications or special needs your student may have. THIS INFORMATION WILL REMAIN CONFIDENTIAL. IT WILL STAY WITH THE SCHOOL TRIP LEADER/NURSE ON THE DAY OF THE TRIP. CONTACT INFORMATION FOR DAY OF FIELD TRIP ONLY:

Primary contact name Relationship to student:

Phone #: Work Phone #: Cell Phone/Pager #:

Secondary contact name Relationship to student:

Phone #: Work Phone #: Cell Phone/Pager #:

Student's Physician: Phone #:

Student's Dentist: Phone #:

TO ANY DOCTOR OR HOSPITAL: I hereby authorize the release of my child's pertinent medical information to the appropriate professional staff. I give permission to the physician or hospital to secure treatment for him/her and to order medications, injections, anesthesia, or surgery for my child, as named above, in case of emergency. The signature below constitutes authorization to perform any necessary treatment for my child during this field trip.

HEALTH INSURANCE INFORMATION:

Company Name: Policy #: Group #:

Parent/Guardian Name: Date:

(PLEASE PRINT)

Parent/Guardian Signature: