POTTSTOWN SCHOOL DISTRICT
FIELD TRIP PERMISSION FORM

_____
Teacher Name

Please complete and return entire form by _____

Dear Parent/Guardian:

Your child _____ has the opportunity to participate in a
(student's name)

field trip to _____ on _____, N/A _____.
(destination) (date) (rain date)

Departure time is _____ and expected time of return is _____.

I give permission for my child to attend the field trip and my child and I agree to comply with the school district policy for field trips (5600).

_____ _____ _____
(*parent/guardian's signature) (phone) (date)

_____ **MONEY ENCLOSED:** ☐ Yes ☐ No
(student's signature) (if applicable)

↓ **Complete for the teacher to take along on the trip.**

STUDENT NAME _____ ROOM/SECTION _____
PARENT NAME/ _____ HOME PHONE _____
ADDRESS _____ ALTERNATE PHONE _____

INSURANCE COVERAGE YES__ NO__ INSURANCE COMPANY_____ POLICY NUMBER_____
MEDICAL ASSISTANCE CARD (DPA) ___,CARD NUMBER_____ RECIPIENT NUMBER_____

STUDENT MUST HAVE INSURANCE COVERAGE IN ORDER TO PARTICIPATE.

EMERGENCY PROCEDURES: IN CASE OF EMERGENCY, I AUTHORIZE THE SCHOOL/REPRESENTATIVE TO OBTAIN OR ADMINISTER EMERGENCY CARE; AND, IF NECESSARY, TO TAKE MY CHILD TO THE CLOSEST MEDICAL FACILITY. I ALSO AUTHORIZE, IF CIRCUMSTANCES REQUIRE, THE EMERGENCY DEPARTMENT PHYSICIAN, OR FAMILY PHYSICIAN OR SCHOOL PHYSICIAN TO PROVIDE INITIAL EXAMINATION AND TREATMENT.

_____
(*parent's signature)

CONTACT INFORMATION:

MOTHER AT _____ PHONE _____
FATHER AT _____ PHONE _____
FAMILY PHYSICIAN _____ PHONE _____

ALLERGIES: SEASONAL ☐ INSECTS ☐ MEDICATION ☐ FOOD ☐ ASTHMA ☐
BLOOD PROBLEMS ☐ CONVULSIONS ☐ HEART PROBLEMS ☐ DIABETES ☐
MY CHILD IS TAKING PRESCRIPTION MEDICATION FOR THE FOLLOWING CONDITION _____
NAME OF MEDICATION _____ PRESCRIBED BY DR._____
OTHER MEDICAL PROBLEMS _____

FOR WHATEVER REASON, ILLNESS, BREACH OF DISCIPLINE, ETC., IT IS THE PARENT'S RESPONSIBILITY TO ASSUME ALL FINANCIAL RESPONSIBILITIES FOR CHAPERONED RETURN OF THE STUDENT.