

**Pottstown School District
Field Trip Permission Form**

Please complete and return entire form by _____

Teacher:

Dear Parent/Guardian:

Your child, _____, has the opportunity to participate in a field trip to _____ on _____. 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)

(student's signature)

Money Enclosed: _____ Yes _____ No
(if applicable) \$

Complete for the teacher to take along on the trip.

Student Name:

Home Room:

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 PHYSICIAN OR SCHOOL PHYSICIAN TO PROVIDE INITIAL EXAMINATION AND TREATMENT.

(*Parent Signature)

CONTACT INFORMATION:

Mother at _____ Phone: _____
Father at _____ Phone: _____
Family Physician _____ Phone: _____

ALLERGIES: SEASONAL ___ INSECT ___ 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 RESPONSIBILITY FOR OBTAINING NECESSARY MEDICAL CARE FOR THE STUDENT.