CLEARVIEW REGIONAL HIGH SCHOOL FIELD TRIP – PARENT PERMISSION

- **Parent will complete the form.**
- **Please forward to the health office 10 days before the trip.**
- **The school nurse will complete a medical review.**

Student ____ Gr. _______
Print
Parent ____
Print
Parent phone number during time of the trip Home #______________________ Work # _____________________ Cell # _______________

Destination of Trip ______________________________ Date ____________________

Depart from school @______________________ Return to school approximately __________________

Cost of Trip: Transportation ___________ Admission ________________ Lunch ___________ Other ________ Total __________

Medical Condition: Please list medical problems (i.e asthma, seizures, diabetes, etc.) that may impact your child's well being.
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Medication: **Only the following medications may be taken on the trip i.e., asthma inhalers, diabetic insulin or Epi-pen or Benadryl for food or insect allergies. No other medication will be permitted.**

Medication ______________________________ Dose ___________ Time ______________

Medication ______________________________ Dose ___________ Time _____________

Physician's Name ______________________________ Phone ______________________

School Nurse Signature______________________________ Date ______________________

I grant permission for my child to participate in the field trip, and for his/her medical condition to be shared confidentially with the field trip advisor.

______________________________ ______________________________
Parent Signature **Date**

Advisor must turn in this permission form to the nurse two weeks before the trip.

______________________________ ______________________________
Advisor's Signature **Date**

______________________________ ______________________________
Nurse's Signature **Date**