To be kept on file for all field trips during the current academic year. LAST NAME _____

DUNBAR CHOIR

PARENT/GUARDIAN PERMISSION FORM FOR FIELD TRIPS and MEDICAL INFORMATION

I am in accord with the purposes of and procedures governing the Field trip. I hereby grant permission for my student to participate. I understand that adequate and appropriate supervision will be provided. I recognize, however, that unanticipated situations and problems can arise on any trip, school-sponsored or otherwise, which situations or problems are not reasonably within the control of the supervising teacher(s) or staff (including volunteers). I further agree to release and hold harmless the Fayette County School District Board of Education, their agents, officers, employees and volunteers, from any and all liability, claims, suits, demands, judgments, costs, interest and expense (including attorneys' fees and costs) arising from such activities, including any accident or injury to my student and the costs of medical services.

In the event of an injury requiring medical attention, I hereby grant permission to the supervising teacher(s) or staff (including volunteers) to attend to my student. If the injury warrants further medical attention, I expect every effort will be made to contact me to receive my specific authorization before action is taken. If efforts to contact me are unsuccessful, I grant permission for necessary medical treatment to be given. In addition, I hereby give my permission to the supervising teacher(s) or staff (including volunteers) to take my student to the Physician, Dentist, or to the hospital if an accident or serious illness occurs on the trip and I cannot be located.

In the event that my student must return to school independently for health, accident, failure to conform to rules established by the teacher in charge, etc. I agree to accept full responsibility for and to pay for the cost of medical care, transportation and other incidental expenses.

STUDENT'S FULL NAME _____ DOB: _____

Please list any medical concerns or past medical history of which we should be aware:

_____

_____

Please check below if you student has allergy or sensitivity that needs to be accommodated on this trip:

☐ Bee Sting ☐ Nuts ☐ Dairy ☐ Latex ☐ Other:
_____

☐ Asthma ☐ Diabetes ☐ Seizure Disorder ☐ Heart Condition ☐ Other:
_____

** If my student requires medication, I understand that I am obligated to ensure that the medication and the (FCPS) Medication Authorization Form are on file prior to the trip and I will supply the medication in the original container on the day of the trip. For a student to self-administer any medication (prescription or non-prescription) the Self-Administration Form must be completed by their parent/guardian and physician. Please note, school staff is NOT responsible for self-administered medications. Controlled substances may NOT be self-administered.

INSURANCE COMPANY_____ POLICY NUMBER _____

SUBSCRIBER NUMBER_____ GROUP NUMBER _____

PERSONAL PHYSICIAN_____ PHYSICIAN'S PHONE _____

Parent Home: _____ Parent Work: _____

Parent Cell 1: _____ Parent Cell 2: _____

Additional Emergency Contact: _____ Relationship: _____

Parent/Guardian Signature _____ **Date** _____