

# OUT-OF-TOWN OR OVERNIGHT TRAVEL FIELD TRIP AGREEMENT AND STUDENT INFORMATION FORM



Today's Date: \_\_\_\_\_

This is to certify that (print) \_\_\_\_\_ has my permission to make the trip to \_\_\_\_\_ from (date) \_\_\_\_\_ to (date) \_\_\_\_\_ with \_\_\_\_\_. I have received and read the Out-of-Town or Overnight Travel Field Trip Booklet (the "Booklet"), and acknowledge that its requirements are incorporated herein.

**Health Information:** Check all that apply:

Asthma       Allergies       Diabetes       Wears Contacts       Arthritis  
 Migraines       Seizures       Nose Bleeds       Convulsions       Other

**Explain Checked Boxes and Identify Any Other Health Concerns:** \_\_\_\_\_

**Parent/Guardian:** Name: \_\_\_\_\_ Phone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

**Emergency Contact:** Name: \_\_\_\_\_ Phone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Insurance Provider      Provider's Phone No.      Policy Number

Insured's Name      Employer      Phone Number

**Request for Administering Prescription Medications to Students:** (Medications must be in pharmacy container with prescription label properly affixed to the medicine in question.)

\_\_\_\_\_ I request that my child be allowed to take the prescription medicine, \_\_\_\_\_ as prescribed by our physician while on the trip. I have read and complied with the requirements for doing so set forth in Part III of the Booklet.

\_\_\_\_\_ I request that my child be allowed to carry and use a self-administered metered dose inhaler containing rescue medication and/or an Epi-Pen as prescribed by our physician. I have read and complied with the requirements for doing so in Part III of the Booklet.

**Administration of Over-the-Counter ("OTC") Medication:** (OTC medications must be in original container and used according to physician's signed written directions which must be attached to this document.) Further explanation is contained in Part III of the Booklet.

\_\_\_\_\_ I give permission for a Rockwood representative to administer \_\_\_\_\_ to my child according to the recommended dosage instructions.

\_\_\_\_\_ I give permission for my child to carry \_\_\_\_\_ and consume or apply this medication(s) as directed by our physician. (grades 9-12 only)

My child and I have read, understand and agree to abide by the requirements set forth in this Agreement, the Booklet and all other expectations and rules set forth by the Rockwood School District and its representatives, including those accompanying students on this trip. I have also received and executed the Out-of-Town or Overnight Travel Field Trip Permission to Participate, Release of Liability and Indemnity Agreement.

I further agree that in an emergency, any Rockwood representative may transport my child to a hospital/medical facility and I authorize any physician or other medical personnel to carry out any diagnostic procedures or emergency care deemed necessary.

\_\_\_\_\_  
Parent/Guardian Name (Print)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student Signature