

DAY TRIP

BROOKFIELD PUBLIC SCHOOLS
PARENT/GUARDIAN PERMISSION AND MEDICAL FORM

Student's Name: _____ Date: _____
Age: _____
Address: _____
Parent Contact: _____ Day Phone: _____ Home Phone: _____
Destination: _____
Purpose: _____
Date: _____ Leave: _____ Return: _____
Supervision: _____ Transportation: _____
Cost: _____ Dress: _____ Lunch: _____

I give permission for my child to attend this field trip.

Signature of Parent/Guardian Date

MEDICAL HISTORY

Allergies: Insect Stings: _____
Food (List): _____
Drug (List): _____

Is your child under the care of a physician for a medical problem? Yes ____ No ____

If yes, please explain: _____

Is your child taking medication prescribed by a physician? Yes ____ No ____

If yes, please list all medications, dosage, time of administration, condition for which
medication is being given and relevant side effects: _____

Other relevant information: _____

CONSENT

To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for 1) the administration of any treatment deemed necessary by a licensed physician or dentist and 2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

Additional medical history may be obtained from:

Doctor: _____

Address: _____

Date Signed: _____ Signature: _____

Parent/Guardian

PLEASE CONTACT THE SCHOOL NURSE FOR THE NECESSARY FORMS TO ADMINISTER PRESCRIPTION MEDICATION ON THE FIELD TRIP AS REQUIRED BY CONNECTICUT STATE LAW. IN THE ABSENCE OF AN RN, ALL EPI PENS GIVEN BY TRAINED STAFF WILL BE ADMINISTERED PER MD ORDERS (NO OBSERVATION FOR SYMPTOMS) CALL 911- CALL PARENT/GUARDIAN

REFUSAL TO CONSENT

I do **not** give my consent for the emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities to take no action or to: _____

Date Signed: _____

Signature: _____

STATEMENT OF INSURANCE

My son/daughter is covered for injury under an insurance policy with: _____

In the case of an emergency or an unanticipated danger, a planned field trip may be cancelled at the discretion of the school principal or designee. In the event of this cause for cancellation, the district is not responsible for the loss of fees or payments incurred by families if expended monies cannot be recovered.