LACKSBURG HIGH SCHOOL BRUINS

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http://bhs.mcps.org/

OVERNIGHT FIELD TRIP PERMISSION FORM

Student Name _____ **Sponsor's Name** _____

Organization _____ **Destination/Activity** _____

Costs for the trip _____

Departure Time from school _____ **AM/PM** **Departure Date** _____, 20_____

Return Time at school _____ **AM/PM** **Return Date** _____, 20_____

TO ENSURE YOUR CHILD'S WELL BEING DURING THIS ACTIVITY, PLEASE PROVIDE THE FOLLOWING:

CURRENT HEALTH ISSUES DIAGNOSED BY A HEALTH PROVIDER:

1. _____
2. _____
3. _____

ALLERGIES:

1. _____
2. _____
3. _____

Please list all medications your child is taking at home and/or at school that will need to be administered on the field trip. Include all regularly scheduled medications, emergency medications (i.e. Inhalers and Epipens) and medications taken as needed (i.e., ibuprofen). A medication staff member will need to carry and administer all medications except for emergency meds where a student has been deemed responsible enough to self carry the medication. A current & up-to-date Medication Administration Sheet must be completely filled out for all medications to be taken, including emergency & over the counter medications. If a medication will be given, the parent must provide the school nurse with the required number of doses in the original bottle at least three days before the field trip is scheduled. Please contact the school nurse with any questions.

☐ **Check here if your child will NOT be taking any medications with them.**

MEDICATION	DOSAGE	Times Taken	Self Carry/ Administered?
			Y / N
			Y / N
			Y / N
			Y / N

I understand, as does my child, that like other school activities, field trips are school-sponsored events, and, therefore, all Montgomery County Code of Conduct and school rules and regulations apply to each event. If my child does not conform to the rules and regulations, he/she will be subject to disciplinary action.

I also give my permission for any emergency medical treatment that may be necessary for my child while participating in the above mentioned activity. I realize that every effort will be made to contact me in the case of a medical emergency and that treatment would be at my expense.

Home/Cell Number_____ **Emergency Telephone#/Contact** _____

E-mail _____ **Preferred Hospital** _____

Family Doctor (Name/Number) _____

Health Insurance Company _____

Health Insurance Policy Number _____

Parental Signature/Date _____**Student Signature** _____