FIELD TRIP PERMISSION FORM
NORWALK HIGH SCHOOL MUSIC DEPARTMENT

Students Name: _____ Sex: _____ Grade: _____
Address: _____ Date of Birth: _____
Home Phone: _____ Student Cell #: _____

Parent/Legal Guardian Information

Parent 1 Name: _____ Parent 2 Name: _____
Parent 1 Cell #: _____ Parent 2 Cell#: _____
Parent 1 E-Mail: _____ Parent 2 Email: _____
Other Responsible Party: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

My child has permission to participate in the field trip to: **ALL Marching Band Trips 2018-2019.**
I give permission to the group leader in charge to seek urgent and/or emergency medical care for my child. The decision for treatment will be made by the medical provider in consultation with the parent /guardian, if possible. This permission will be used only after efforts to reach a parent /guardian has been made. Furthermore, I agree to waive all claims against the leaders /chaperones of this activity for seeking urgent and/or emergency medical care for my child. I also agree to pay all costs and assessments associated with my child being a member of the marching band (uniform parts, band jacket, trips, instrument repairs, etc…).

Parent / Guardian Signature: _____ Date: _____

Health Information (give dates where known)

Surgery within the last year? ☐ Yes / No ☑
Motion Sickness? ☐ Yes / No ☑
Under Medical treatment at the present time? ☐ Yes / No ☑
If yes, give reason: _____

_____

Allergies (food and/or medicines) – please list: _____

_____

Chronic Health Diagnosis (asthma, diabetes, epilepsy etc.): _____

_____

Special Health Concerns: _____

_____

Emotional Concerns: _____

_____

Menstral Cycle Problems: _____ Date of last Tetanus Vaccine: _____

Name of Student's Medical Provider/Doctor: _____

Medical Provider/Doctor Phone: _____ Fax: _____

Student's Medical Insurance: Name of Company: _____

Policy # _____ Insured Adult / Policy Holder_____

Insurance Company Phone Number: _____

Medical Information (complete section below if necessary)

Student's Name: _____ Date of Birth: _____

List all medications your child takes (including herbal preparations & vitamins):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

My child may need to take the medication listed on the attached forms during the field trips.

Prescribed medications must be in the original pharmacy container and include the student's name, prescription number, name of medication, dosage and directions for administration. I give permission for the school staff to administer the prescribed medication(s)** to my child _____.

(Name of student)

SEE ATTACHED DOCTOR PERMISSION FOR THE ADMINISTRATION OF MEDICATION.

Parent / Guardian Signature: _____ Date: _____

** Over the counter medications that have been prescribed by your child's medical provider must be in an unopened container. An **AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL** form, signed by a doctor, must be provided for each medication to be administered.