



## FIELD TRIP PERMISSION FORM

We (I) as parent(s) or legal guardian(s) of \_\_\_\_\_

*Student's Name*

give permission for our child to participate in:

**Field Trip:** Fanny Chapman Park

**Date of Trip:** TBD

**Cost:** \$0

**Means of Transportation:** Walk

This permission includes all related programs or events associated with the field trip. In consideration for our (my) child's participation, we (I) and my (our) child agree and understand that we (I) assume the risks inherent in the field trip, and with full knowledge of the risks, we (I) agree to release and hold harmless OLMC School, OLMC Parish, and the Archdiocese of Philadelphia and their employees and representatives, from claims arising or related to our (my) child's participation.

Our (my) child understands and agrees to abide by all rules and regulations established by the school pertaining to such field trip.

We (I) consent to and give permission for emergency medical care for our (my) child that may be needed as a result of our (my) child's participation.

**Insurance:**

**Group #:**

**I.D. #:**

\_\_\_\_\_  
*Student's Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Parent's/Guardian's Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Parent's/Guardian's Signature*

\_\_\_\_\_  
*Date*

N.B. Each student **must** return the signed permission form before being permitted to participate on the field trip.

(over)

## EMERGENCY CONTACT INFORMATION

A parent or guardian can be reached at the following telephone numbers on the day of the activity:

Home Phone: \_\_\_\_\_

Mother's work phone: \_\_\_\_\_

Father's work phone: \_\_\_\_\_

Other contact person: \_\_\_\_\_

Phone: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

A nurse will not be available to administer medication(s) on field trips. Parents must package medication(s) at home and deliver it (them) to the teacher in a sealed envelope. Medication(s) that must be delivered in person will need to be given directly to a child's teacher by a parent. On the envelope please indicate the name of the child, the name of the teacher, the name of the medication(s), the dosage(s) and the time(s) the medication(s) will need to be given. The child will be required to self administer his/her own medication(s) under the supervision of the teacher.

\_\_\_\_\_  
*Parent's Signature*

\_\_\_\_\_  
*Date*