

I hereby give my permission for \_\_\_\_\_  
(name of student)

who attends \_\_\_\_\_  
(school)

to participate in a field trip to \_\_\_\_\_  
(destination)

on \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ for the purpose of \_\_\_\_\_  
(date)

Transportation for this activity will be provided by:

District bus/vehicle

Other \_\_\_\_\_

As parent, or legal guardian, my student will not attend this event if they are exhibiting symptoms of Covid19 and/or were instructed by a public health or medical professional to self-isolate or self-quarantine because of concerns about Covid19.

As parent, or legal guardian, I authorize a qualified physician to examine the above-named student and in the event of injury to administer emergency care and to arrange for any consultation by a specialist, including a surgeon, as deemed necessary to insure proper care of any injury. I understand that every effort will be made to contact parent or guardian to explain the nature of the problem prior to any involved treatment.

In the event it becomes necessary for Lake Washington School district staff-in-charge to obtain emergency care for your student, neither the staff-in-charge nor Lake Washington School District assumes financial liability for expenses incurred because of accident, injury, illness, and/or unforeseen circumstances.

Student address: \_\_\_\_\_

Student home phone: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Describe any medical condition, including allergies that could impact the student's field trip experience:

None  See below

\_\_\_\_\_  
\_\_\_\_\_

On the line below, please print parent/guardian name, and home, work and/or cellular phone number:

\_\_\_\_\_

In the event of an emergency (injury, illness and unforeseen incident), the following person must be notified in case the parent/guardian cannot be contacted:

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

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

I have read the attached itinerary and understand that the school district will make every reasonable effort to provide a safe environment during the field trip. As the parent/guardian of the above-named student I understand that there are inherent risks associated with participation in these activities including physical injury, and/or other consequences. I acknowledge that school rules apply on all field trips.

I received a detailed itinerary  yes  no

I received a list of things to bring (if any)  yes  no

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

## EXTENDED FIELD TRIP EMERGENCY INFORMATION

DATE \_\_\_\_\_

NAME OF STUDENT \_\_\_\_\_ SCHOOL \_\_\_\_\_

PARENT/GUARDIAN NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_

MOTHER'S CELL PHONE \_\_\_\_\_ FATHER'S CELL PHONE \_\_\_\_\_

MOTHER'S WORK PHONE \_\_\_\_\_ FATHER'S WORK PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

STUDENT'S HEALTH CARE PROVIDER \_\_\_\_\_ PHONE \_\_\_\_\_

HEALTH CONDITION(S) STAFF SHOULD BE AWARE OF \_\_\_\_\_

**WILL YOUR CHILD BE BRINGING ANY MEDICATIONS ON THE FIELD TRIP?**

YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, an Authorization to Administer Medication form must be filled out and signed by both the parent and the child's healthcare provider. This form is available on the district website [www.lwisd.org](http://www.lwisd.org). Go to the section For Parents, Student Health and Student Health Forms. You can also obtain the form from the school office.

**PRESCRIPTION MEDICATIONS, OVER THE COUNTER MEDICATIONS, NUTRITIONAL SUPPLEMENTS, AND HERBAL REMEDIES REQUIRE AN AUTHORIZATION TO ADMINISTER MEDICATION FORM SIGNED BY YOUR CHILD'S HEALTH CARE PROVIDER. PLEASE PROVIDE ONLY THE NUMBER OF PILLS YOUR CHILD WILL NEED DURING THE FIELD TRIP PLUS TWO EXTRA PILLS AS BACK UP. THIS WILL PROVIDE ADEQUATE MEDICATION IN THE EVENT A PILL IS DROPPED OR IF THE STUDENTS ARE DELAYED IN THEIR RETURN TO SCHOOL.**

**PRESCRIPTION MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION BOTTLE AND LABELED CORRECTLY.** The label must include the student's name, name of the medication, dosage, time the medication is to be given, expiration date, and the health care provider's name.

**PARENTS MUST LABEL OVER THE COUNTER MEDICATIONS.** It must include the student's name, dosage and the time the medication is to be given. This must match the healthcare provider's orders.

**NO STUDENT MAY SELF-CARRY MEDICATION WITH THE EXCEPTION OF AN EPIPEN AND/OR INHALER.** This must be stated on the Authorization to Administer Medication form and signed by both the parent and the healthcare provider.

**BRING ALL MEDICATIONS AND MEDICATION ORDERS TO SCHOOL BY \_\_\_\_\_**

If you have any questions, please contact the district nurse by calling the school office.

Sincerely

Principal

District Nurse