STUDENT TRAVEL/FIELD TRIP INFORMATION and PARENT CONSENT FORM

Group/Team: _____ **# Students attending:** _____

Faculty Leader Name(s): _____ **# of Chaperones:** (including Ldr) _____

Trip Destination: _____

Trip Date(s): _____

Anticipated Departure Time: _____ **Anticipated Return Time:** _____

Transportation by: _____

Driver(s) (if other than school /commercial carrier)**:** _____

In An Emergency, How Can Trip Leader(s) Be Contacted:

FOR OVERNIGHT TRIPS:

Accommodations: Physical address, phone _____

Provisions for Mixed Gender Supervision: _____

PRE-TRIP PARENT MEETING (for Trip involving Three (3) or More Overnights) WILL BE:

Date: _____ **Location:** _____ **Time:** _____

Group/Team: _____

Staff Ldr: _____

Trip name: _____

PARENT CONSENT FORM for STUDENT TRAVEL/ FIELD TRIP

PARENT / STUDENT CONSENT

I hereby give my permission for _____ (son/daughter's name) to participate in the travel/field trip(s) named and described herewith. I acknowledge receipt of the Field Trip Information form for that trip(s). I am comfortable with the arrangements described. I authorize the trip leader(s) to arrange medical treatment in an emergency. I hereby release the trip leader, the field trip(s) chaperones, the school, and the school department ("School"), town of Cape Elizabeth ("Town"), and all of their agents or employees, from any and all claims, liabilities and responsibilities for damages or injuries that my son/daughter may experience during this trip, except only any claims for any damages or injuries that may be sustained as a result of any intentionally harmful acts on the part of the trip leader, the chaperone(s), the Town, the School, or their agents or employees. I understand that it is my responsibility to obtain health insurance coverage for medical expenses that may occur.

_____ _____

Parent Signature | Student Signature (if 18 or older)

_____ _____

Date | Date

EMERGENCY CONTACT AND MEDICAL INFORMATION FORM

Student Name: _____ **DOB:** _____

Health Insurance Provider: **Plan/Certificate #:**

1st Contact: _____ **Relationship:** _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

2nd Contact: _____ **Relationship:** _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Non-Parent Contact: _____ **Relationship:** _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Known Allergies? If yes, provide treatment protocols below:

_____

Medication or Treatment Restrictions:

_____

Medication(s) that student will be bringing for self-administration:

_____