

Paradise Valley Unified School District No. 69
FIELD TRIP PERMISSION FORM

| STUDENT INFORMATION | | |
|--------------------------------|---------------------|----------------------------|
| STUDENT'S FIRST NAME | STUDENT'S LAST NAME | DATE OF BIRTH (MM/DD/YYYY) |
| MAILING OR STREET ADDRESS/APT# | | CITY, STATE, AND ZIP CODE |
| SCHOOL NAME | | HOMEROOM TEACHER/GRADE |

| FIELD TRIP INFORMATION | | | |
|----------------------------|-----------------------|--------------------|--|
| FIELD TRIP DESTINATION | | DATE OF FIELD TRIP | MEANS OF TRANSPORTATION: |
| DEPARTURE TIME FROM SCHOOL | RETURN TIME TO SCHOOL | COST OF TRIP | PLEASE CONTACT ME IF A PARENT VOLUNTEER IS NEEDED: YES NO |

| EMERGENCY CONTACTS | | |
|---|--------------------------------|--|
| For precautionary measures, please provide us your phone number at home OR the phone number where you may be reached on the day of the field trip. In addition, please provide us one or two other contacts (a relative, friend, or sitter, etc) and their phone numbers in case of an emergency | | |
| NAME OF PARENT/GUARDIAN TO CONTACT | PHONE NUMBER OF PARENT CONTACT | INDICATE PHONE # TYPE <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL |
| NAME/RELATIONSHIP ADDITIONAL CONTACT | PHONE NUMBER OF CONTACT | INDICATE PHONE # TYPE <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL |
| NAME/RELATIONSHIP ADDITIONAL CONTACT | PHONE NUMBER OF CONTACT | INDICATE PHONE # TYPE <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL |

| MEDICAL INFORMATION | |
|---|--|
| NAME OF MEDICAL INSURANCE PROVIDER | INSURANCE NUMBER |
| SPECIAL MEDICAL INSTRUCTIONS TO FOLLOW: | <input type="checkbox"/> PARENTAL WAIVER (No Insurance) |
| DATE OF LAST TETANUS | KNOWN ALLERGIES (LIST ALL, including medication allergies) |

While on this field trip, the sponsor has my permission to administer to my child the following medication(s). If several, please attach list, including all allowable over-the-counter drugs and prescriptions.

Medications(s) _____

Dosage(s) _____ Time(s) _____

| PVUSD SPONSORED TRAVEL |
|---|
| Water facility usage is permissible while traveling if activity is staffed with certified lifeguards. |
| STUDENT'S SWIMMING ABILITY STATEMENT – REQUIRED if traveling to Water Facility |
| There are inherent risks in using water facilities. If you choose to have your child participate, you accept those risks. |
| Please mark one of the boxes below to indicate that you are aware of your child's ability to swim or to be near any pool of water. By signing this permission slip, you are stating that you accept the risks involved in using water facilities. |
| MY CHILD HAS THE APPROPRIATE LEVEL OF SWIMMING SKILLS TO SAFELY PARTICIPATE IN ALL WATER PARK ACTIVITIES: |
| ♦For all other water related field trips see attached form for information regarding the activities involved. |
| <input type="checkbox"/> YES |
| <input type="checkbox"/> NO |

| PARENT SIGNATURE REQUIRED |
|--|
| I allow _____ to attend the field trip that has been scheduled. If any illness or injury occurs, I authorize a school representative to obtain emergency treatment for the above student at the closest medical facility unless instructed otherwise by paramedics or according to the special instructions listed above. I understand that the school assumes no responsibility other than the exercise of prudent supervision. All medical expenses will be covered by my own medical carrier. |
| PARENT/GUARDIAN SIGNATURE FOR FIELD TRIP: _____ DATE: _____ |
| PARENT/GUARDIAN SIGNATURE FOR EMERGENCY MEDICAL TREATMENT: _____ DATE: _____ |