



CA Middle Field Trip Permission and Consent-to-Treat Form

Teacher's Name Ms. Arnott, Mr. Johnson, Mrs. Tatum

Our Class is planning a field trip. Listed below are all the pertinent details about this trip.

PLEASE RETURN THIS FORM TO THE TEACHER!

Date Sept. 6-8 Destination Camp Ocoee

Departure Time Sept. 6, 9:30am Return Time Sept. 8, 3pm

Transportation Buses Adult Chaperons(s) Teachers and additional parent chaperones
Fee parent Lunch Arrangements sack lunch
students - \$0
chaperones - \$120.

Purpose/Instructional Value outdoor education

Special Requirements _____

I/We, the undersigned, hereby grant permission for _____
to participate in the above activity.

I/We do hereby agree to release from any and all liability and otherwise hold harmless all school personnel acting in their supervisory capacity for personal injury, property or other type of loss which occurred as a result of this activity.

I/We further authorize the above mentioned chaperones to seek and arrange for emergency medical care, dental care, hospitalization or surgery that may become necessary in my absence and I/we will assume financial responsibility for same. (Every effort will be made on the part of the school to contact the parent(s) first.)

The Collegedale Academy sponsors and the school officials will make every reasonable effort to properly supervise, control, and render safe all activities in the planned program above.

Student Signature _____ Parent's Signature _____ Emergency Phone _____

List any special medical requirements or allergies: _____

Health Information Form - Please complete

Student Name: _____

Has your child ever had an allergic reaction? (please specify)

Hay fever: ___ Poison Ivy: ___ Insect Stings: ___ Other: _____

Penicillin: ___ Other drugs: ___ Asthma: ___ Foods: ___

Please Describe:

Does your child have other special considerations?

Chronic or recurring illness: _____

Emotional/behavior challenges: _____

Activities encouraged or limited: _____

Special Diet: _____

Immunization Info needed for the following:

Tetanus: _____ (date of most recent date of immunization and/or booster)

Over-The-Counter Medications (by checking the appropriate line, I give permission for my child to receive the following medications according to specific product label unless otherwise directed by a physician.

Symptom

Medication

Headache, Fever

Acetaminophen (Tylenol) _____ Ibuprofen _____

Cramps, Muscle Pain, Inflammation

Ibuprofen _____

Upset stomach

Maalox _____ Mylanta _____ Pepto-Bismol _____

Diarrhea

Kaopectate _____ Imodium Liquid _____

Localized Allergic Reactions

Benadryl _____

Sore Throat

Sore Throat Lozenge _____

Itching (Rash)

Hydrocortisone Cream _____ Calamine Lotion _____

Insect Sting

Insect Bite Relief (Sting Kill) ointment

Without specific parental authorization, no oral medication will, or can be given.

List any over-the-counter oral or topical medications which your student should not receive.

(Over)

ALL MEDICATIONS BROUGHT ALONG, BOTH PRESCRIPTION AND NON-PRESCRIPTION, MUST BE IN THE ORIGINAL CONTAINERS AND CLEARLY LABELED WITH NAME. All prescription medications will be dispense according to physician instructions.

Prescription and Routine Medications/Vitamins

Please list all medications brought by student to be taken regularly throughout the time at camp listing exact dosage and dispensing orders prescribed by your doctor.

Medication/Vitamin	Dosage	Times taken (Breakfast, lunch, supper, bed)

This health history is correct so far as I know.

Signature of parent/guardian: _____

Date: _____