



Lower School (Grades K-4)
Field Trip Permission Form

TEACHER ALERT FOR MEDS: YES

Dear Parents,

Please complete the permission form below, keep the bottom portion of this form, and return it to your child's teacher by:

- 1. My child, ..., may/may not (please circle) attend the field trip to ...
2. I would like to chaperone this trip with my child. (Teacher will confirm chaperones.)
3. Will your child need any special medication during this time period?

For purposes of an emergency, I can be reached at:

Phone #1 Phone #2 Phone#3

Parent Signature: Print Name:

If for some reason your child is unable to attend the scheduled trip, please be advised that all transportation costs and prepaid admission fees will not be refunded.

The school will provide transportation via bus or van and will transport based on the following:

- > Kindergarten through 4th Grade is not required to ride in a safety seat on a school bus.
> Kindergarten through 1st Grade is required to ride in a federally approved child safety seat on a school van if the child is under the age of 8 and less than 65 lbs. See Special Instructions below if your child is required to bring a booster seat on the field trip.

PLEASE SEE REVERSE FOR MEDICATION ADMINISTRATION

Field Trip Destination: Teacher's Name

Date: Time of Departure: Time of Return:

Cost per Student:

Special Instructions (check one): Please provide a federally approved child safety seat
Bring lunch and drink
Other



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**Parent/Guardian Permission to Assist
With Medication to Student on Field Trip**

I give permission for _____ to go on _____ on
(Student's Name) (Specify field trip)

_____. I understand a staff member will assist my child with medication. Information
(Date)

about the medication that needs to be taken by _____ is as follows:
(Student's Name)

Name of medication _____

Dose (amount to be taken) _____

Time to be taken _____

How it is taken _____

I understand I must send the medication in the original container.

All of the above information is on the label on the container prepared by the pharmacist
as prescribed by:

(Doctor's Name)

The following are any allergies or health conditions my child has:

Please contact your school nurse Mrs. Ashkenase, RN or Mrs. Croce, RN if you have any questions
at 302-378-3179 ext. 340 or nurse@saintannesschool.org)

-----Tear Off-----