FIELD TRIP PERMISSION FORM

I. SPONSORING TEACHER INFORMATION Date_____

_____ is seeking permission to go on a field trip.
Name of Student

LEHIGH UNIVERSITY on WED, AP. 5 THUR, APRIL 6 FRI, AP 7, SAT APRIL 8 from 6:00 AM.
Destination Day and Date Dismissal from class

to 9:00 PM supervision of BEN PREDDY. Transportation to be
Arrival time Teacher's name

provided by HAVERFORD SCHOOL DISTRICT in the form of SCHOOL VANS, MENTOR & PARENT CARS.
School District (specify) Van/Bus/Other

**Special considerations (cost, lunch, proper attire, etc.
*** Any special medical conditions, complete reverse side of form

Emergency Contact Arrangements

BRING $ FOR BREAKFAST & LUNCH SNACKS _____

II. STUDENT RESPONSIBILITY

The student has the responsibility to have this form completed and returned to the sponsor/teacher at least **1 week prior** to the trip date. This form must be returned to the sponsor/teacher no later than MARCH 28th. If you fail to do so, you will not be
Due Date

permitted to attend the trip. **STUDENTS ARE RESPONSIBLE FOR ANY WORK MISSED AND ARE TO SEE TEACHERS TO MAKE ARRANGEMENTS.**

III. TEACHER INFORMATION

Teachers whose classes are to be missed must sign below using a full last name. Your signature does not signify permission, but indicates that you have been notified of this trip.

**A in the parenthesis below indicates that the teacher has concern about this student missing his/her classes.

Block 1 _____( )

Homeroom _____( ) Students are <u>not</u> to be marked absent on the day of the trip.

Block 2 _____( )

Block 3 _____( )

Block 4 _____( )

IV. Parent's Approval - Please read carefully.

_____
Parent Signature

Please fill out Completely

School of District of Haverford Township
Haverford High School;
200 Mill Road – Havertown, Pennsylvania 19083 610.853.5900.2001/2527
STUDENT MEDICAL AUTHORIZATION
(trips overnight and greater than fifty miles)

I_____ hereby grant permission for the properly designated school personnel to have emergency care rendered to my child_____ He/she is under their supervision/care.

Parent's Name_____

Address_____

Phone/Cell_____

Work Phone_____

Medical Insurance (Name & Numbers)_____

Personal Physician Phone#_____

Relative or friend who may be contacted (two)

Name_____ Name_____

Relation_____ Relation_____

Phone_____ Phone_____

Medical History (Fill in the blanks where applicable)

Allergies (including medications)_____

Epilepsy_____ Diabetes_____

Bee Sting_____ Other_____

Daily Medication (Name and Frequency)_____
_____

I assume financial responsibility for any medical bills. I further release the school district and its representatives from responsibility for any problems that might be incurred as a result of medical care and or treatment.

Parent Signature_____ Date_____

please fill out other side →