

Student's Last Name:

ANNUAL FIELD TRIP RELEASE/EMERGENCY MEDICAL FORM

**Plumstead Christian School
5765 Old Easton Road – Box #216
Plumsteadville, PA 18949
(215) 766-8073**

This form will be on file at the school office for the _____ school year. An additional permission slip will be sent home prior to each off-campus trip.

I give permission for _____, grade _____, to participate in all school-sponsored trips away from the school premises throughout the current school year. Students will be accompanied by a teacher and will be under adequate supervision. I understand that I will be given at least forty-eight hours notice of all trips away from the school premises. I further understand that I may revoke permission for a specific field trip by written notice to the principal more than one week prior to the trip.

Although the school desires to provide a safe and enjoyable time for all students, accidents can still happen. I/we understand that there are risks/dangers involved with participation in off-campus trips and their associated activities. In consideration of my child being allowed to participate in the trip, I/we agree to assume responsibility for those associated with the travel and activities. I/we agree to hold harmless Plumstead Christian School, its employees and representatives, including volunteer and other drivers, from any and all claims arising from my child's participation. This release agreement does not apply to claims of intentional misconduct or gross negligence by the school, its employees, or volunteers.

In case of accident, illness, or other emergency, I/we request that Plumstead Christian School contact me. If PCS cannot reach a parent/guardian after conscientious effort, I/we give permission for school staff to call paramedics or any licensed physician or dentist. If a life-threatening emergency exists, I/we give permission for school staff to call paramedics immediately and then contact me/us as soon as possible thereafter.

I/we authorize and consent to any X-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care, which, in the best judgment of a licensed physician or dentist, is deemed advisable. I/we agree to assume the financial responsibility for expenses incurred as a result of those services being provided. I/we also agree to be financially responsible for emergency medical transportation. In cases where medical care is needed but the situation is not an emergency, PCS will make every effort to contact parents before treatment is given.

Father/Guardian's Signature: _____ Today's Date: _____

Name Printed: _____

Mother/Guardian's Signature: _____ Today's Date: _____

Name Printed: _____

Physician _____

Phone _____

Dentist _____

Phone _____

Health Insurance Carrier _____

Policy # _____

Under name of _____

Relationship to student _____

Turn over to complete student medical information



Allergies (including reactions to medications):

Medication(s) being taken while on trip (must be given to trip coordinator in original prescription bottle):

Physical or medical conditions we should know about not already stated?

Student's home phone number: _____

Student's home address:

FATHER

MOTHER

Work # _____

Work # _____

Cell Phone # _____

Cell Phone # _____

In case of emergency, who is your nearest relative or neighbor we should contact if we are unable to contact you at home or work?

Name _____

Phone _____

Relationship to student _____

**You will be sent home a permission slip form
before each trip to update medical information.**