



# WAKE COUNTY PUBLIC SCHOOL SYSTEM

## PARENTAL CONSENT AND STUDENT MEDICAL INFORMATION FOR SCHOOL TRIPS

BY SIGNING THIS CONSENT FORM, I CERTIFY THAT I HAVE READ AND UNDERSTAND THE INFORMATION BELOW AND THAT ANY INFORMATION I HAVE PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. **IF THIS FORM IS NOT COMPLETED AND RETURNED BY \_\_\_\_\_, THE STUDENT WILL NOT BE PERMITTED TO PARTICIPATE AND WILL REMAIN AT SCHOOL IN A SUPERVISED ACTIVITY.**

Trip or Activity Planned: AOF Trip

students will participate in a variety of off campus learning experience that will enrich the AOF curriculum.

Date(s) of Trip \_\_\_\_\_

Purpose of Trip or Activity

School Sanderson High School

Name of Teacher/Sponsor

Academy of Finance

Method of Transportation  WCPSS vehicle  charter bus/contract vehicle  \*privately-owned vehicle

*\* When privately-owned vehicles are used for transporting students, only the vehicle owner's liability coverage is applicable to any vehicular accident. When students are transported by vehicles owned by Wake County Public School System, the school system vehicle liability coverage is applicable to any vehicular accident.*

### Changes/Cancellations

I understand school trips may be cancelled when necessary by the principal, superintendent, or board of education. The school system cannot guarantee reimbursement when such cancellations occur. Parents/guardians will be notified of any significant change in plans prior to the school trip.

### Expectations and Instructions

I understand the following is expected of the student:

- To follow instructions given by the teachers/chaperones.
  - Not to leave or separate from the group without appropriate authorization from a teacher/chaperone.
- Comply with all school and district policies and rules of conduct.

In the event any of the above expectations or instructions are violated, I understand school officials reserve the right to remove the student from the trip and the student will be subject to school disciplinary consequences.

### Insurance Coverage

I represent that the student has insurance either through the school system's student insurance program or through my own insurance carrier.

I request that \_\_\_\_\_ (student) **be allowed to participate in the trip and/or activity planned and, recognizing the risks inherent in the trip and/or activity planned, specifically consent to the student's participation. In the event of an accident or a medical emergency, I authorize school officials to seek and consent to emergency medical assistance on the student's behalf. I will assume responsibility for all expenses. I understand that school officials will use the contact information provided below to attempt to contact me in the event of such accident or emergency.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

*This form must be kept with school officials at all times during the school trip.*



# WAKE COUNTY PUBLIC SCHOOL SYSTEM

Parent/Guardian Name \_\_\_\_\_ Day Phone ( ) \_\_\_\_\_

Home Address \_\_\_\_\_ Evening Phone ( ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Phone ( ) \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

## School Trip Health Information

*In the event that the routine medical needs of any student attending the school trip cannot be met by school employees, a licensed nurse may be required to attend. Parents of students with medical needs will be contacted directly by the assigned school nurse. In the event of an accident or emergency, the below information may also be provided to emergency medical providers as needed.*

- Student has no medication(s) and/or needs no medical assistance during this school trip
- Student requires medication(s) and/or medical assistance during this school trip (\*complete information below)
- Parent/Guardian will be attending the school trip and will provide medication(s) and/or medical assistance for this student

\*List all daily and emergency medications (including dosage and time taken) that will be needed during this school trip

Medication	Dosage	Time

Does the student require medical assistance, other than the administration of medication(s)?

- Yes       No

If yes, describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all allergies: \_\_\_\_\_

\_\_\_\_\_

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