**‍Hoop and Bat for Mental Health Wellness**

**FIELD TRIP PERMISSION FORM and OVERNIGHT EVENTS**

# Overnight/Day Trip Field Trip Event To

Supervising Coach

Date/Time of Departure Date/Time of Return

**Student’s Name →**  has my permission to participate in the school field trips event listed above which requires an overnight stay.

Age

Gender: F / M Home Phone

Student Phone

Home Address City State Zip Family Physician/Clinic Office Phone Parent/Guardian Cell Phone Work Phone **In an emergency, please notify:**

Name Relationship Home Phone Cell Phone Work Phone Home Address City State Zip

**Health History**

Please check all allergies participant may have and briefly describe the reaction:

Insect stings/bites Seafood

Asthma (allergy induced) Food (wheat/nuts/other)

Hay Fever Penicillin Other

Please check below if participant currently has or has had any of the following:

|  |  |  |
| --- | --- | --- |
| CONDITION | Past | Currently Has |
| Heart Defect/Disease |  |  |
| Diabetes |  |  |
| Hypertension |  |  |
| Epilepsy |  |  |
| Bleeding/Clotting Disorders |  |  |
| Asthma |  |  |
| Other |  |  |

***\*\*\* Please complete the reverse side. \*\*\****

# Please complete the following questions:

1. Are there any specific activities to be encouraged, limited, or avoided? **YES NO**

If yes, please explain.

1. Is the participant able to swim? **YES NO**

Please circle level of ability: beginner intermediate advanced

1. Does participant have a current tetanus shot? **YES NO** Date of shot:
2. List current medications (please send with directions to be administered during trip)
3. I give permission for my child to be administered the following as needed for minor discomfort while on the educational field trip (check all that apply):

Tylenol Benadryl Cough Drops Tums Other

1. Does your child have any special dietary considerations? **YES NO**

If yes, please provide detailed information.

1. Please provide any other important health related information about your child

Will your child need to take any medication during field trips even outside normal school hours? **YES NO**

If yes, please provide the necessary times and instructions for administering medication. ***The medication must be carried out by the teacher. Provider order is required.***

Does your child have any health conditions or require special accommodations that chaperones on the field trip should be aware of? **YES NO** If yes, please explain:

Please provide a primary and a back-up telephone number where a parent or designated authorized person can be reached during the field trip.

**Primary Back-up Please sign below to indicate permission for your child to go on school field trips which require an overnight stay. Parent/Guardian Date**

Medical Waiver, Release & Authorization to Administer Medication

1. I give permission for HOOP AND BAT FOR MENTAL HEALTH WELLNESS program staff to provide routine healthcare, first-aid, administer prescribed and over-the-counter medications as described and seek emergency medical treatment for my above-named child.

2. I give permission for HOOP AND BAT FOR MENTAL HEALTH WELLNESS program staff to arrange for medical transportation, if necessary, for my above-named child.

3. In case of emergency, I understand that all reasonable efforts will be made to contact me.

But, in the event I cannot be reached, I hereby give permission for medical personnel selected by HOOP AND BAT FOR MENTAL HEALTH WELLNESS’s designated healthcare/emergency staff to secure and administer medical treatment including hospitalization, order and administer medications, anesthesia, X-rays, surgery or special procedures if deemed medically necessary for the above-named child.

4. I hereby understand that all medical costs are my financial responsibility and agree to pay for all charges associated with procuring or providing medical care to the above-named child.

5. I hereby grant permission to HOOP AND BAT FOR MENTAL HEALTH WELLNESS program staff to administer insect repellant and /or sunscreen as needed to the above-named child. I understand that it is my responsibility to provide my child with adequate sun/bug protection and any application made available by HOOP AND BAT FOR MENTAL HEALTH WELLNESS program staff is a supplemental precaution.

6. I give permission for the following over-the-counter medications to be administered to my child if necessary due to injury and/or illness, according to the manufacturer’s recommendations.

**Please sign below to indicate acknowledging and giving authorization to Hoop and Bat for Mental Health Wellnes.**

**Parent/Guardian Date**