

FINDING THE LOST SHEEP/Offsite Field Trip Permission Slip

IMPACT CENTER PERMISSION SLIP/EMERGENCY FORM

Please complete this form that will accompany your child on the field trip. This information is necessary should we need to contact you while we are away from the center. No child will be allowed to participate without this form being completed and signed by the parent or guardian. The information on this form is considered confidential and will accompany the field trip leader off site.

Permission is granted for: _____ (print)

to take a trip to the **Orlando Repertory Theatre** by **SHUTTLE BUS** on December 11, 2021. Time of departure is **12:00 p.m.** and time of return is **4:30 p.m.**.

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name: _____

Address: _____

Phone #: _____ Emergency Phone #: _____

Please provide the information requested below, as it may be needed in case of an emergency. This information does not modify the information on the emergency card.

Student's Date of Birth _____

Allergies: _____

Conditions requiring special consideration (medical/physical): _____

Does your student require: (A) **Epipen** Yes No (B) **Inhaler** Yes No (C) **ANY MEDICATION CURRENTLY TAKEN:** (Type of medication and time of administration): _____

Please be sure to speak to Pastor Sharee before **December 11th** regarding any medications or special needs your child may have. **THIS INFORMATION WILL REMAIN CONFIDENTIAL. IT WILL STAY WITH THE FIELD TRIP LEADER ON THE DAY OF THE TRIP. CONTACT INFORMATION FOR DAY OF FIELD TRIP ONLY:**

Primary contact name _____ Relationship to child: _____

Phone #: _____ Work Phone #: _____ Cellphone: _____

Secondary contact name _____ Relationship to child: _____

Phone #: _____ Work Phone #: _____ Cellphone: _____

Child's Physician: _____ Phone #: _____

Child's Dentist: _____ Phone #: _____

TO ANY DOCTOR OR HOSPITAL: I hereby authorize the release of my child's pertinent medical information to the appropriate professional staff. I give permission to the physician or hospital to secure treatment for him/her and to order medications, injections, anesthesia, or surgery for my child, as named above, in case of emergency. The signature below constitutes authorization to perform any necessary treatment for my child during this field trip.

HEALTH INSURANCE INFORMATION:

Company Name: _____ Policy #: _____ Group #: _____

Parent/Guardian Name: _____ Date: _____

(PLEASE PRINT)

Parent/Guardian Signature: _____