Angleton ISD Student Travel Guidelines

Activity or Field Trip Permission Form

Campus: Angleton High School Theatre Department

_____will be participating in the following activity or field trip:
student's name

Activity/Field Trip: Texas Thespians Competition Grapevine TX

Date(s): ***From*** Weds Nov 20 @ 10AM ***To:*** Sat Nov 23, 2024 Leaving after ceremony 3/4PM

Location: 1501 Gaylord Trail Grapevine TX 76052 817-778-1000

Scheduled time of departure: 3/4 PM **Scheduled time of return:** 9PM eta or earlier

Type of transportation ***(if off campus)***: Sams Limo Charter Bus

If your child breaks an Angleton ISD, Theatre Department, or Thespian rule and has to leave the premise:

_____ ***(initial)*** I understand that I must retrieve my child at my own expense

Parent/Guardian: Please complete the section below and return to school

Student's Name: ***(Print)***_____

Phone number in case of emergency: ***(Area code)*** **(_____)** _____ - _____

Name of Parent/Guardian: (*Print*) _____

Signature of Parent/Guardian: _____

Date: _____/_____/_____

Cancellation: Unforeseen situations can result in cancellation, or a student may become ineligible to participate in the event. In such cases, Angleton ISD assumes no financial responsibility for any monies lost due to this action.

Angleton ISD Medication Consent

Please provide the following information and provide a copy of your insurance card in case of emergency.

Student: _____

List any known drug/food allergies: _____

List medical conditions (asthma, contacts, etc.): _____

Non-Prescription / Over-the-Counter (OTC) Medication Authorization

If available, a First Aid kit, with approved OTC items, may be provided for minor ailments.

____ *(initial)* I ***do not*** give consent to staff to administer any non-prescription medication to my student.

____ *(initial)* I give consent to staff to administer non-prescription medications to my student as initialed below:

Please initial each medication that can be administered:

_____ Acetaminophen _____ Ibuprofen _____ Antihistamine/Decongestant _____ Sore Throat Lozenges

_____ Antacids _____ Anti-Diarrheal _____ Electrolyte _____ Menstrual Pain Reliever

I hereby certify that my student has no known drug allergies _____ (initial).

Prescription Authorization

I request that AISD staff administer medication/s listed below to my student according to the physician's instructions. I agree to furnish an adequate amount of medication in the original container at the time of travel.

Medication/s: _____ _____

_____ _____

Note: Medications may be updated/added at the time of travel and additional forms may be attached as needed. Medications will be administered according to the physician's instruction on original container.

Parent/Guardian Signature _____

Phone (W) _____ **(C)** _____

2nd Emergency Contact Name _____

Phone (W) _____ **(C)** _____

Note: Under the Texas Tort Claims Act school districts have governmental immunity and are not liable for injuries that are not a direct result of negligent operation or use of a motor vehicle and/or flight