

ST. DIDACUS SCHOOL FIELD TRIP PERMISSION SLIP

*PLEASE RETURN THIS
PERMISSION SLIP ON
OR BEFORE*

A field trip is a privilege, not a right. Your child, guardianship, is eligible to participate in a school-sponsored activity at a location away from the school site. This activity will take place under the guidance and supervision of employees and parents from St. Didacus School. A brief description of the activity follows:

CURRICULUM GOAL: _____

DESTINATION: _____ **STUDENT COST** _____

DESIGNATED SUPERVISOR OF ACTIVITY _____

METHOD OF TRANSPORTATION: _____ Lunch Brown Bag () yes () No lunch required we will be returning back to school)

DATE OF FIELD TRIP: _____ () Yes, I can drive (____) # of passengers

DEPARTURE TIME: _____ **ANTICIPATED TIME OF RETURN:** _____

If you are requesting that your child participate in this event, please complete, sign and return the following request for participation. As parent or legal guardian, you remain fully responsible for any legal responsibility, which may result from any personal actions taken by named student.

WE HEREBY RELEASE AND HOLD HARMLESS ST. DIDACUS SCHOOL ANY AND ALL OF ITS EMPLOYEES OR PARENTS FROM ANY AND ALL LIABILITY AND FOR ANY AND ALL HARM ARISING TO MY CHILD AS A RESULT OF THIS TRIP.

I request that my child _____, a student in Grade _____, be allowed to participate in the event described above. I understand that this event will take place away from the school grounds and that my child will be under the supervision of the designated school employee on the stated date. I further consent to the conditions stated above for this event, including the method of transportation.

Parent/Guardian Signature Date

Street Address City State Zip Code

EMERGENCY TELEPHONE NUMBER _____ (Day) Cell _____

EMERGENCY MEDICAL TREATMENT: In the event of any emergency, I hereby give permission to transport my child to a hospital for emergency or surgical treatment. I wish to be advised prior to any further treatment by hospital or doctor. In the event of an emergency, if you are unable to reach me at the above number, contact:

Name Relationship to Student Telephone Number

Family Doctor Telephone Number

I ALSO AUTHORIZE THE DESIGNATED SUPERVISOR TO ADMINISTER MINOR FIRST AID TREATMENT TO MY CHILD.

Parent/Guardian Signature Date