WEST CHESTER AREA SCHOOL DISTRICT

ADMINISTRATIVE GUIDELINE
APPROVED: August 1, 2015
REVISED:

121AG2 PERMISSION FORM

Parent/Guardian:

The school authorities encourage educational trips under suitable conditions as part of class work. We are glad to have your child go with the group on the trip named below:

1. Place (Itinerary): Hershey Park

2. Date: May 31, 2024 Starting hour: 7:30 ✔ am pm
Est. Return hour: 10:00 am ✔ pm

3. Teacher(s) in Charge:
Mrs. Yagel, Mr. Hill, Mr. Celfo

4. Transportation: Bus

5. Cost to Pupil: $140 (trip fee + shirt)

6. Name of Pupil:

7. Building: Fugett MS

8. Special Instructions from School:
Payment is available on Payschools link OR cash/check to WCASD

9. If your child has medical considerations or medical needs, please list here and attach the completed Field Trip Medical Information/Field Trip Medication Administration Form – 121AG6.

Important: All arrangements for any medication that will be necessary on a field trip must be made with the nurse before the day of the trip.

Parent/Guardian Signature: _____
Address:
Phone:
Email:

☐ I am willing to serve as a chaperone on this field trip.

WEST CHESTER AREA SCHOOL DISTRICT

No. 121AG6

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121AG6 FIELD TRIP MEDICAL INFORMATION FORM

(Please complete pages 1 & 2 and return to the student's teacher with the Permission Form 121AG2)

Name of Field Trip: Fugett Music in the Parks Trip Location of Trip: Hershey Park

Student Name: _____ Building: Fugett MS

Teacher: Mr. Celfo, Mr. Hill, Mrs. Yagel Grade: _____ Homeroom: _____

IN CASE OF ILLNESS OR ACCIDENT NOTIFY:

PARENT/GUARDIAN

Relation	Name	Employer	Work Phone #	Cell Phone #	Home Phone #
Father ☐ Step ☐					
Mother ☐ Step ☐					
Guardian ☐					

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

ACCIDENT INSURANCE

Name of Insurance Company: _____

Policy Number: _____

Allergies: _____

Medical Conditions: _____

PLEASE PROCEED TO PAGE 2
REVIEW IMPORTANT INFORMATION REGARDING MEDICATIONS AND THEIR ADMINISTRATION AND PROVIDE ADDITIONAL SIGNATURES

I give permission, at no expense to the school district or its personnel, to take my child or to transport by ambulance, to the nearest available doctor or hospital in case of medical emergency while on the above-named trip.

PARENT/GUARDIAN signature: _____ Date: _____

121AG6 FIELD TRIP MEDICATION ADMINISTRATION FORM

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Name of Field Trip: Fugett Music in the Parks Trip Location of Trip: Hershey Park

Student Name: _____ Building: Fugett MS

Teacher: Mr. Celfo, Mr. Hill, Mrs. Yagel Grade: _____ Homeroom: _____

Name of Parent/Guardian *(please print):* _____

Please note: We are required to have written physician orders to administer medications. Physician written orders already in place at the school nurse's office need not be duplicated. HOWEVER, doctor's signatures are required for any OTHER medications with which the school nurse has not been involved (i.e. once daily meds that are given on awakening or at bedtime). Please have him/her complete and sign below.

Some field trips will not have a professional nurse present. In that case, no over the counter medications may be given. If a nurse is going on the trip, I give permission for the nurse to give my child:

Tylenol ☐ yes ☐ no Benadryl ☐ yes ☐ no Advil ☐ yes ☐ no Antacids ☐ yes ☐ no

on the trip as deemed necessary.

MY CHILD REQUIRES THE FOLLOWING ESSENTIAL MEDICATIONS:

DIAGNOSIS	MEDICATION	DOSAGE	TIME	ROUTE

ALL MEDICATIONS MUST BE IN THEIR ORIGINAL, LABELED CONTAINERS FROM HOME. PLEASE SEND ONLY THE AMOUNT NEEDED FOR THE TRIP.
DO NOT SEND LOOSE MEDS IN BAGGIES-THEY WILL NOT BE GIVEN

All medication must be given to the nurse (*or lead teacher, if there is no nurse*) upon arrival to school on the day of the trip (*or before*). They will be turned over to the supervising adult upon departure. Medications and the signed forms must be received on or before the time of departure or will not be given.

HEALTH CARE PROVIDER (*Pediatrician or Family Doctor*):
I certify as the Health Care Provider that the above stated medications are to be given to the above named student while on the above-named trip.

_____ _____

HEALTH CARE PROVIDER signature & phone number Date

PARENT/GUARDIAN:
I, as the parent/guardian, wish to have the above stated prescription medication(s) taken by the above named student during the above named trip.

_____ _____

PARENT/GUARDIAN signature & phone number Date