Child's Full Name: _____ Teacher: _____

Yearly Approval for Type 1 Field Trips

Type 1 field trips are walking field trips of one mile or less.

VERBAL APPROVAL WILL NOT BE ACCEPTED

Does the student have special health problems or handicapping conditions which will require individual monitoring or supervision on field trips? (Please update this information on a regular basis)

☐ No ☐ Yes If _____

_____

_____ yes, what is the problem and what special considerations should be given to the student? _____

I authorize New City School to take _____ on all Type 1 field trips this current school year. (Student's Full Name)

I understand that the necessary arrangements, plans, and precautions will be taken for the care and supervision of the student during field trips and that I will be notified before each field trip takes place. I understand that it is my responsibility to notify the school immediately if I do not want my child to attend a particular field trip.

_____ Date: _____

Parent/Guardian Signature

Student Health Information

Clinic/MD: _____ Phone: _____
Dentist: _____ Phone: _____
Preferred Hospital: _____
List any health problems: _____
List any allergies (medication or other): _____
List any medications: _____
Has your child's physical activity ever been restricted? If yes, when? For what? _____

_____
Has your child ever been hospitalized for illness/surgery/injury? If yes, when? For what? _____

_____
Has your child ever received professional counseling? _____

During the 2017-2018 school year, I authorize New City School to (please check items you authorize):

☐ Provide screening and diagnosis in the school district and cooperating districts.
☐ Release information related to these services to your doctor, dentist, counselor or public health agency.
☐ Initiate treatment following verbal approval from parent or guardian.
☐ Release information on treatment provided at school to your health insurance for billing purposes and request that payment from the health insurance be paid directly to the Service provider for any benefits due under the terms of this insurance policy. There would be no payment made by you for this service.

_____ Date: _____

Signature of Parent/Guardian