PIONEER VALLEY CHRISTIAN ACADEMY
PHILADELPHIA/WASHINGTON D.C. TRIP
PERMISSION SLIP & EMERGENCY MEDICAL FORM

Student Name ______________________________ Phone # ________________ Date of birth _____________

Address ____
(Street) (City) (State) (Zip)

Mother ______________________________ Work Phone # ___________ Cell Phone #____________

Father ______________________________ Work Phone # ___________ Cell Phone #____________

EMERGENCY CONTACT

Please give an emergency contact person.

Emergency Contact__________________________ Work Phone # ___________ Cell Phone #____________

SATURDAY NIGHT PICK-UP PERSON

Please list the name and phone number of the person responsible for picking up on Saturday evening (1/7/23).

Name____Phone number _____________________________

INSURANCE INFORMATION

Name of person who carries the student's insurance____

Health insurance company________________________________Insurance Policy # ___________________

MEDICAL INFORMATION

Student is allergic to ____

Does student have any chronic health conditions? Yes __No ___ If yes, please explain _________________

____

____

Any additional information the chaperones should be aware of __________________________________

____

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OVER THE COUNTER MEDICINE

No student will be administered any OTC medicines without parental permission. Please check any medications that you give permission to administer. The directions on the box will be followed, unless parents give instructions otherwise. If this section is not filled out, the student WILL NOT be administered any OTC medications.

☐ Tylenol ☐ Advil ☐ Rolaids/Tums ☐ Pepto-Bismol

☐ Imodium AD ☐ Benadryl

MEDICATIONS

Any prescription medications or OTC medications given on a daily basis must be submitted to **Mrs. Maynard** on Tuesday morning (1/3/23) before leaving on the trip. All medications must be in the original packaging or in a prescription bottle sealed in a zip-lock bag with the student's name and the directions for administering it.

Please provide the following information for each medication to be administered on the trip. Medication includes prescription, over-the-counter, and homeopathic/herbal.

Medication #1________________________Dosage __________Time to administer____________

Check one ☐ As needed ☐ Daily Time(s) to be given AM________ PM________

Reason for giving____

Special Instructions____

What to do if a dose is missed or late? ____

Medication #2________________________Dosage __________Time to administer____________

Check one ☐ As needed ☐ Daily Time(s) to be given AM________ PM________

Reason for giving____

Special Instructions____

What to do if a dose is missed or late? ____

Medication #3________________________Dosage __________Time to administer____________

Check one ☐ As needed ☐ Daily Time(s) to be given AM________ PM________

Reason for giving____

Special Instructions____

What to do if a dose is missed or late? ____

MEDICAL PERMISSION

IN CASE OF ACCIDENT OR ILLNESS, I request the chaperones contact me, if possible. In the event the chaperones are unable to reach me, I hereby authorize the chaperones to administer any type of medical attention necessary.

____ ______________________

Parent(s) Signature *Date*

By signing this form, I (parent or guardian), ________________________ certify that I request and give my permission for ________________________ to go to **Philadelphia/Washington, D.C. from Tuesday, January 3 – Saturday, January 7, 2023.** I release the chaperones from all liability and waive any claims against them.

____ ______________________

Parent(s) Signature *Date*