



EDUCATIONAL TOURS, INC.

TRIP RELEASE FORM

_____ HAS MY PERMISSION TO ACCOMPANY
(Student's Legal Name)

_____ TO _____ ON _____
(School Name) (Destination) (Travel Dates)

I ALSO GIVE MY PERMISSION FOR MY CHILD TO: *(Check if applicable)*

_____ Swim in a pool or ocean that may not have a lifeguard. _____ Ride a bicycle or horse, if available.

_____ Ride roller coasters or theme park rides. _____ Use motorized watercraft or jet skis.

_____ Participate in all trip activities.

EMERGENCY CONTACT INFORMATION

STUDENT'S LEGAL NAME: _____

SOCIAL SECURITY NUMBER: _____ **BIRTH DATE:** _____ / _____ / _____
(Optional, but may be needed)

PARENT'S/GUARDIAN'S NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____ **OFFICE PHONE:** _____

CELL PHONE: _____

IF UNABLE TO CONTACT PARENTS, PLEASE CONTACT:

NAME: _____ **PHONE:** _____

RELATIONSHIP: _____

PHYSICIAN'S NAME: _____ **OFFICE PHONE:** _____

INSURANCE COMPANY: _____

INSURANCE POLICY NUMBER: _____

MEDICAL INFORMATION

STUDENT IS ALLERGIC TO: *(Check if applicable)*

_____ Bee/Wasp Stings _____ Peanuts/Peanut Oil _____ Milk Products
_____ Egg Products _____ Hard Shell Fish

Other: _____

STUDENT IS ALLERGIC TO THE FOLLOWING MEDICATIONS: *(Check if applicable)*

_____ Penicillin _____ Sulfa _____ Aspirin

Other: _____

STUDENT IS SUBJECT TO: *(Check if applicable)*

_____ Frequent Fainting _____ Sleep Walking _____ Epileptic Seizures
_____ Heart Condition _____ High Blood Pressure

Other: _____

MEDICAL RELEASE

I, _____ **HEREBY GIVE MY PERMISSION FOR THE ASSIGNED ADULT ON**
(Parent/Guardian)

THE TRIP TO ADMINISTER THE FOLLOWING MEDICATIONS IF NECESSARY.

_____ Tylenol _____ Benadryl _____ Aspirin
_____ Antacid/Pepto Bismol _____ Ibuprofen/Motrin _____ Cold/Sinus medications

Please list any medications that your child will need to take while on the trip. All medications must be sent in their original containers and properly labeled with the student's name, medication name, dosage amount, and administration time. Students will be allowed to self-administer asthma relief/control inhalers and eye medications. Remember to also list any non-prescription items such as vitamins or herbal supplements:

MEDICATION NAME:

DOSAGE:

ADMINISTRATION TIME:

STUDENT RECEIVED THEIR LAST TETANUS SHOT ON: _____

MEDICAL TREATMENT/DISCIPLINARY RELEASE

If I, the undersigned, or the authorized physician named cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the perception of school authorities, I authorize that my child be taken to the hospital for emergency medical treatment. I agree to reimburse the school for any medical costs that might be incurred by my child while on the trip.

I also understand that in the event that my child does not comply by the rules given to them or by the rules of the school, they may lose privileges. Consequences may be handled upon return to the school or they may be flown home at my expense and I will not receive a refund of any kind. Major violations include, but are not limited to:

**Possessing illegal drugs, cigarettes, or alcohol • Conducting oneself in an inappropriate manner •
Causing harm to another person • Causing damage to property**

(Parent/Guardian Signature)

(Date)