SOUTH COUNTRY CENTRAL SCHOOL DISTRICT

FIELD TRIP PERMISSION SLIP

A. Trip Information: Destination: Bellport Middle School ~ Grade 5 Student Orientation

Location and Phone Numbers: 35 Kreamer Street, Bellport, NY 11713 (631) 730-1726

Date: Monday, May 7, 2018 Time of Departure from District 8:45am

Date: Monday, May 7, 2018 Time of Return to District 10:15am

Chaperones: Classroom Teacher

Class or Sponsoring Club____

B. Insurance Information: The Certificate of Insurance Student Accident policy now used in the South Country Central School District covers all school sponsored and supervised activities, even those away from the school. This policy provides reasonable and customary benefits for medical expense to a maximum of $50,000.00 as a result of any one covered accident. The Student Accident policy will pay those covered balances for which benefits are not provided by the parent's primary insurance carriers in excess of $25.00. These insurance payments are secondary and based on usual and customary charges within the limits of the policy.

C. Permission Slip: I hereby give my son/daughter_______________________________________ permission to participate in the above trip; sponsored by South Country Central School District. I understand that the above mentioned insurance coverage applies only to currently enrolled students of South Country Central School District.

D. Student Academic Responsibility: I am aware that my son/daughter is responsible for any academic work missed during the trip.

Date: _______________Signature Parent/Guardian: ___________________________________

Address: ____

Telephone: _____________________Emergency number: _______________________________

Emergency Contact Name: ____

(To be taken with chaperones on trip – MUST BE FILLED IN COMPLETELY)
Emergency Medical Treatment Release: In case of an emergency, I hereby give permission to the adult supervisor on the field trip to secure proper medical treatment, including hospitalization, if necessary for my child, ____

Date of last tetanus shot: ______________________Unusual medical conditions including allergies to medication: ____

Date: __________________ Signature of Parent/Guardian: ____________________________________

Telephone: ________________Emergency name & phone: _____________________________________