

**PARENT PERMISSION FORM FOR FIELD TRIP PARTICIPATION**

Your son/daughter is eligible to participate in a school-sponsored activity requiring transportation to a location away from the school building. This activity will take place under the guidance and supervision of employees from St. John School. A brief description of the activity follows:

Name and Purpose of: \_\_\_\_\_

Destination: \_\_\_\_\_

Supervisor(s) of Activity: \_\_\_\_\_

Date/Time of **(Departure)** \_\_\_\_\_

**(Return)** \_\_\_\_\_

Method of Transportation: Town of Winslow – Bus                      Student Cost: - 0

Your child needs to bring: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you will like your child to participate in this event, please complete, sign, and return the following statement of consent and release of liability. As parent or legal guardian, you remain fully responsible for any legal responsibility that may result from any personal actions taken by the named student.

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**(RETURN THIS PORTION)**

I request that St. John School allow my child \_\_\_\_\_ to go with \_\_\_\_\_ on a field trip to \_\_\_\_\_.

Transportation to and from the destination will be by the Winslow Bus. I understand my child will leave school on **(Departure)** \_\_\_\_\_ **(Return)** \_\_\_\_\_.

I hereby indemnify and hold harmless St. John School and the Diocese of Portland and any of their official representatives from any claims of damages resulting to my child on this field trip and/or while in transit to or from the event, unless said injuries were proven to be the result of the negligence of St. John School or it's agents. Furthermore, I authorize to have my child treated for emergency medical or dental problems that should result from injuries received, providing a licensed physician or dentist advises such treatment. I accept full responsibility for all costs of such emergency treatment.

Health Insurance Company \_\_\_\_\_

Subscriber \_\_\_\_\_ Policy Number \_\_\_\_\_

Does your child take medicine on a regular basis?    Yes [ ]    No [ ]

May we give your child this medicine?    Yes [ ]    No [ ]

(If yes) Medicine Name: \_\_\_\_\_ Times to Be Given: \_\_\_\_\_

May we give your child Tylenol for a headache?    Yes [ ]    No [ ]

Please indicate any allergies your child may have: (bee-stings, bug bites, etc.)  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

**\*Please return this entire form by: \_\_\_\_\_.**