

# SHS Tennis Team Trip to International Tennis Hall of Fame – Newport, RI – Saturday, 3/23/2024

## PERMISSION AND EMERGENCY FORM

Please complete this form that will accompany your child on the field trip. This information is necessary should we need to contact you while we are away from the school. No student will be allowed to participate without this form being completed and signed by the parent or guardian. The information on this form is considered confidential and will accompany the school trip leader/nurse on the trip.

Permission is granted for:

(Name of Student) PLEASE PRINT- \_\_\_\_\_  
STUDENT'S CELL # \_\_\_\_\_

**to take a trip to the International Tennis Hall of Fame, Newport, RI by bus on Saturday, March 23rd –  
COST is \$40.00 cash or check made payable to Simsbury High School – FORM AND PAYMENT DUE 3/12/2024  
Time of departure is 8:00AM and time of return is 5:00 PM VIA BUS**

### PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name: \_\_\_\_\_

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

Phone #: \_\_\_\_\_ Emergency Phone #: \_\_\_\_\_

Please provide the information requested below, as it may be needed in case of an emergency. This information does not modify the information on the emergency card.

Student's Date of Birth \_\_\_\_\_

Allergies: \_\_\_\_\_

Conditions requiring special consideration (medical/physical): \_\_\_\_\_

Does your student require: (A) **Epipen** Yes  No  (B) **Inhaler** Yes  No  (C) **ANY MEDICATION CURRENTLY TAKEN:** (Type of medication and time of administration): \_\_\_\_\_

Please be sure to speak to the Nurse before \_\_\_\_\_ **3/08/2024** regarding any medications or special needs your student may have. **THIS INFORMATION WILL REMAIN CONFIDENTIAL. IT WILL STAY WITH THE SCHOOL TRIP LEADER/NURSE ON THE DAY OF THE TRIP. CONTACT INFORMATION FOR DAY OF FIELD TRIP ONLY:**

Primary contact name \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Cell Phone/Pager #: \_\_\_\_\_

Secondary contact name \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Cell Phone/Pager #: \_\_\_\_\_

Student's Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_

Student's Dentist: \_\_\_\_\_

Phone #: \_\_\_\_\_

**TO ANY DOCTOR OR HOSPITAL:** I hereby authorize the release of my child's pertinent medical information to the appropriate professional staff. I give permission to the physician or hospital to secure treatment for him/her and to order medications, injections, anesthesia, or surgery for my child, as named above, in case of emergency. The signature below constitutes authorization to perform any necessary treatment for my child during this field trip.

### HEALTH INSURANCE INFORMATION:

Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

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

(PLEASE PRINT)

Parent/Guardian Signature: \_\_\_\_\_