SCHODACK CENTRAL SCHOOL DISTRICT
1477 South Schodack Road
Castleton-on-Hudson, New York 12033
Fax 518-732-7710

JASON M. CHEVRIER
Superintendent
518-732-2297

CHRISTIAN OLSEN
President
Board of Education

SCHODACK CENTRAL SCHOOL DISTRICT
IN DISTRICT FIELD TRIP FORM
2018-2019

Dear Schodack CSD family,

From time to time during the course of the school year, your child's class will take short "field trips" in the vicinity of the school. Such trips could be walking trips conducted as a class activity under the supervision of a classroom teacher, other school personnel and parent volunteers or bus transportation between buildings.

Your signature on this form indicates your permission for your child to participate in such field trips.

You will be notified by separate permission slip of any trip requiring that your child be transported out of district.

Please return this form to your child's teacher.

I give permission for my child _____,
(Student Name – Please Print)

in _____ class to participate in field trips of the
(Teacher Name)

nature described above during the 2018-19 school year.

_____
(Name of Parent/Guardian – Please Print)

_____
(Signature of Parent/Guardian) (Date)

CASTLETON ELEMENTARY SCHOOL
James Derby, Principal
518-732-7755

MAPLE HILL JR/SR HIGH SCHOOL
Jacqueline Hill, Principal
518-732-7701

SCHODACK CENTRAL SCHOOL DISTRICT
FIELD TRIP
STUDENT PERSONAL/MEDICAL PROFILE

(PLEASE PRINT)

Name: Last	**First**	**Middle Initial**
Date of Birth:		
Address:		
Town:		**Zip Code:**

Parent Name: Last	**First**	**Middle Initial**
Telephone:		
Home:	**Work:**	**Cell:**

Emergency Contact: Last	**First**	**Middle Initial**
Home:	**Work:**	**Cell:**

	Medical Information	
Insurance Carrier	**Policy#**	**Physician**
Medications:		
Allergies:		**Other Medical Conditions:**

Is your child taking any medication with him/her on the trip? _____ If so, what is the medication and who is expected to administer this medication? _____

In the event of an emergency or non-emergency situation requiring medical treatment, I hereby grant permission for any and all medical and/or dental attention to be administered to my child, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

_____ _____

(Signature of Parent/Guardian) (Date)

Original: Teacher
Copies: Office File