



Activity/Field Trip Information Guide

OVERNIGHT/OUT-OF-STATE FIELD TRIP CHECK LIST

Teachers, Sponsors/Coaches, Administrators

Admin	Teacher	
_____	_____	The field trip provides clear educational value, is in support of instructional objectives, and outweighs any class time that may be missed.
_____	_____	The building administrator has approved the field trip.
_____	_____	The principal's supervisor has approved at least 30 days prior to the field trip (except for CHSAA sanctioned events).
_____	_____	The field trip sponsor has reviewed all field trip policies and procedures, has prepared permission slips, has considered the needs/requirements of special needs students (including health needs), and has confirmed access to emergency contact information.
_____	_____	The sponsor has arranged for adequate adult supervision. Non-staff chaperones must be background checked in accordance with the district volunteer application process.
_____	_____	14 days prior to the trip, the sponsor has collected permission slips for each student attending the field trip, including acknowledgment signed by parent and student that the school's code of conduct applies.
_____	_____	14 days prior to the trip, the sponsor provided a copy of the completed medical information & release forms to the administrator and school nurse.
_____	_____	14 days prior to the trip, all expenses (transportation, registration, entry fees, substitutes, etc.) are either budgeted or those monies are collected and communications have taken place with the bookkeeper.
_____	_____	At least 14 days prior to the field trip, Transportation (Academic/Activity Trip Request) forms are filled out, signed, and routed to Transportation.
_____	_____	Prior to the field trip, a Field Trip/School Activities Approval form is filled out, signed, and submitted to the principal - allowing sufficient time for additional approvals.
_____	_____	The teacher has requested a guest teacher and prepared a detailed lesson plan for the guest teacher.
_____	_____	The teacher/sponsor has planned an appropriate alternate activity for students who are unable to participate in the field trip.

- _____ Any PO or check requests needed is submitted at least 5 days in advance of the trip. If seeking reimbursement, all original receipts must be submitted to the bookkeeper upon return and have prior approval
- _____ Sponsors have access to emergency contact information throughout the entirety of the trip and are familiar with all procedures to be followed during the field trip.
- _____ A plan to develop a roster of students going on the field trip is prepared and ready to give to the bus driver prior to leaving for the event (given just before departure).
- _____ A plan is in place to inform staff of the students who will not be in school due to the field trip.
- _____ Appropriate supervision and attendance checks are planned and in place for airports, trains stations, rental vehicles, excursions, and other unstructured activities or venues sponsors and students will encounter.

QUESTIONS SHOULD BE ADDRESSED TO THE SUPERVISING PRINCIPAL OR
ASSISTANT PRINCIPAL

FIELD TRIP/SCHOOL ACTIVITIES REQUEST FORM

Teacher Name: _____ Departure/Return Date: _____

Destination: _____

Mode of Transportation: ☐ Dist. Bus ☐ Charter Bus ☐ Rental Car*
☐ Privately Owned Vehicles* ☐ Other list _____

Purpose of Trip: _____

Number of Chaperones: _____ List Chaperones On Reverse.

School Time Missed by Students: _____

Is a travel agency arranging the trip? No ☐ Yes ☐

If yes, list name address, phone # and contact person for agency: _____

Students will leave school at: _____ Students will return to school at: _____

Approximate cost, per student, of trip: _____

Cost covered by: ☐ Student ☐ District ☐ Fund raising ☐ Other, list _____

If expenses are part of budget, list account Number: _____

Have permission slips been prepared? YES ☐ Attach a copy of permission slip, itinerary, and
any other information that describes the trip, purpose, destination, cost, etc.

If medication will be needed for student(s), does the staff member who will be assigned to give
the medication have current medication training and certification through an approved Colorado
state medication class? ☐ YES ☐ NO CPR/First Aid Trained ☐ Yes ☐ No

Sponsor Signature: _____ Date: _____

Principal Approval: _____ Date: _____

Principal Supervisor Approval: _____ Date: _____

Attach student list who will attend the field trip, by gender. Indicate which students have a 504
plan, health care plan, or IEP. Provide to the school nurse 2 weeks before the trip for
appropriate planning.

**If using rental car or POV, drivers must be included on the reverse of this form and must have passed the district's
small vehicle class, as per EEA-E and EEA-E-2. **No arrangements for the trip can be made until approved by
the site principal and, if overnight/out-of-state, the principal's supervisor.** Substitutes must be arranged by the
teacher through the school office. Transportation requests are available through the office. **Return completed forms
no less than 30 days before trip.***

Copy — Office Copy — Student Services Copy — Teacher

List names of adults who will be driving and transporting students in rental or personal vehicles.
Communicate requirements identified in administrative policy EEA-E and EEA-E-2 to all drivers
and

<u>Driver Name (Last, First)</u>	<u>Driver meets requirements of EEA-E and EEA-E-2?</u>		<u>Transp. Admin. Approval</u>
1. _____	YES	NO	_____
2. _____	YES	NO	_____
3. _____	YES	NO	_____
4. _____	YES	NO	_____
5. _____	YES	NO	_____
6. _____	YES	NO	_____
7. _____	YES	NO	_____
8. _____	YES	NO	_____

[illegible]

**(SAMPLE)****ACADEMY DISTRICT 20 FIELD TRIP PERMISSION FORM**

Teacher Name(s): _____ Class or Group: _____

Student Name: _____

Purpose of Activity: _____

Destination: _____ Date of Trip: _____

Mode of Transportation: _____ Departure Time: _____

Departure Location: _____ Return Time: _____

Return Location: _____

Cost of Trip per Student: _____

I understand that the School District is not responsible for insuring my student with regard to the student's participation in the activity. I am responsible for obtaining any medical, accident, or other insurance that I may deem appropriate. I understand, however, that the student and I retain any legal rights we may have for Personal Injury Protection Coverage, to the extent it may be available, resulting from a motor vehicle or bus accident. I understand that the School District and its employees may have certain legal protections and immunities from liability with respect to any property damage or personal injury that may occur during the activity. The School District and its employees have not waived these protections and immunities. I understand that the School District and its employees may also have certain legal obligations with respect to the activity. I understand that if my child needs medication while on a trip and cannot self-medicate, I will accompany my child or there will be a staff member who has current medication training and certification assigned to provide the medication to my child. In addition, I understand that school nurses may only be available only during normal school hours. I understand that the student's participation is entirely voluntary and the school will provide alternatives for those students who cannot participate in the activity. **All District policies and procedures apply to the trip regardless of where the activity takes place. Violation of the policies/procedures or failure to follow directives, safety rules, etc. could result in the student being sent home and/or disciplined.** I acknowledge that I have read and understand this Trip Permission Form.

Signature of Parent or Legal Guardian _____

Guardian Printed Name _____ Date ____/____/____

Student Signature _____

Student Printed Name _____ Date ____/____/____

EMERGENCY CONTACT INFORMATION WILL BE PULLED DIRECTLY FROM INFINITE CAMPUS. Please go to asd20.org/homeinfo to verify and/or update your student's emergency contact information.

CONFIDENTIAL
MEDICAL INFORMATION AND RELEASE FORM

Student Name _____ Birth Date _____

HEALTH QUESTIONNAIRE

Does your child have a medical diagnosis of which the school needs to be aware?

☐ YES ☐ NO

If yes, please list _____

Does your child take any medication on a regular basis or under certain conditions (as needed)? ☐ YES ☐ NO

If yes, please list medication name, dosage, frequency, purpose (please print information below)

Is your child on a Health Care Plan? ☐ YES ☐ NO

Is your child on a 504 Plan? ☐ YES ☐ NO

Does your child have asthma? ☐ YES ☐ NO

If yes, is your child authorized to self-carry an asthma inhaler? ☐ YES ☐ NO

Does your child have a seizure disorder? ☐ YES ☐ NO

Does your child have diabetes? ☐ YES ☐ NO

Does your child have a diagnosed life threatening allergy? ☐ YES ☐ NO

If yes, is your child authorized to self-carry an epi-pen? ☐ YES ☐ NO

Does your child have any food restrictions/sensitivities? ☐ YES ☐ NO

If yes, please list _____

Please describe the type of reaction that could occur with accidental ingestion of substance listed above and plan of action for school personnel. _____

Please provide any other information that you would like us to be aware of regarding the health, safety, and welfare of your son/daughter, including any physical limitations, drug

allergies or environmental sensitivities severe enough to cause a reaction.

To the best of my knowledge, my son/daughter has no illness, communicable disease, or physical disability that will interfere with his/her participation in this activity.

In case of an accident or other emergency, I authorize Academy District 20 staff to call 911, authorize medical care for this student at the nearest health facility, and to release the medical information disclosed on this form. I understand that the school nurse is responsible for the student's health care needs only during normal school hours on school grounds. Alternative arrangements maybe necessary for administration of medication.

Parent/Guardian Signature_____

Printed Name_____ Date_____

Student Signature_____

Printed Name_____ Date_____

This completed form is required in order for your child to participate in a school field trip.

[This must be submitted to the administrator and the school nurse at least **2 weeks prior** to the field trip.] Failure to furnish this information may result in denial of your student's opportunity to participate.

Permission to Administer Medication

Parents are encouraged to administer medication to their children outside of school hours if at all possible. Only medications which are required to enable a student to stay in school may be given at school. ***Any prescription changes will require an additional signed and completed Permission to Administer Medication Form.*** If necessary, medications (prescription and over the counter) can be given at school under the following conditions:

1. All medications must be ordered by healthcare providers with prescriptive authority in Colorado (MD's, DO's, NP's, PA's, Dentist's).
2. All medication forms must be renewed each **school year**.
3. Written permission by parent and physician in all cases.
4. Medications must be in the original, properly labeled container. Medications sent in baggies or unlabeled containers will not be given.
5. All medications must be kept in the health room, except for students whose doctors require them to carry medications on their person (for example, epi-pen, inhalers, etc).
6. High school students generally may transport, self-carry and self-administer their own medications. Students cannot self-carry or self-administer controlled substances.

**The information/form below must be completed and signed by the physician.
In addition, the medication bottle must match the prescription as written below.**

STUDENT NAME (first last): _____

SCHOOL: _____ GRADE _____ DOB _____

MEDICATION: _____ DOSAGE: _____

TIME TO BE GIVEN: _____ ROUTE: _____

If PRN, (as needed) please note the minimum duration time between doses (for inhalers, minimum time frequency, frequency between sets of inhalation): _____

Anticipated time frame: (Must be renewed each school year)

School Year: _____ OR Specific Time Frame: FROM _____ TO _____

If medication is an inhaler or epi-pen, has a health care provider authorized its use? __Yes __No

(If yes, please see attached contract to self-carry). **For epi-pens and inhalers, a health plan is required.** Physician, HP or PA Initials: _____

Is a second dose allowed if there is an allergic reaction? ☐ YES ☐ NO

Physician/NP/PA Signature _____ Physician/NP/PA Phone No. _____ Date _____

Permission to Administer Medication

I hereby give permission for (print name)_____ to take the above prescription(s) at school as ordered by the physician. I understand that it is my responsibility to furnish this medication(s). I also understand that all medications must be transported to and from school by a parent/guardian or approved emergency contact person. **I give my permission for school staff to contact the prescribing physician regarding this medication. I release Academy District #20 and its staff from any claim which may arise out of the administration or failure to administer medication to my student.**

Parent/Guardian Signature _____ Date _____

Updated 9/1/2018