

Columbus School  
315 N. Kansas St.  
Edwardsville, IL 62025

**EDUCATION TOUR PARENT APPROVAL FORM**

Date 9-11-09

Dear Parents:

<sup>Ms.</sup> ~~Mr.~~ Duncan's 4<sup>th</sup> grade class from Columbus school will take an educational tour to the Watershed Nature Center in Edwardsville on Wednesday, October 7, 2009

Students will leave the school at 9:30 a.m. and will return at approximately 11:30 a.m.

The purpose of the tour is to culminate our Forest Unit in our science curriculum

To meet the actual expense of the tour, the cost per student will be 0 payable to the teacher prior to the tour. Transportation will be provided by school bus walking (circle one).

Lunch arrangements will be: at school, regular schedule

Supervision of the students on the tour will be provided by teachers parents (circle one or both).

Please return this note to the teacher by September 30, 2009 so that your child may join this educational tour.

Thank You!

Ms. B. Duncan

While the school endorses well-planned tour activities as a valuable part of the extracurricular program and of classroom instruction, it can assume responsibility for the safety and welfare of students while they are off-campus only to the point of reasonable provision for their supervision by members of our staff.

Date

Parent/Guardian Signature

Name of Student

I would like to help chaperone.

\* Please remember to fill out reverse side.

**Edwardsville Community Unit School District 7**

*Dr. Ed Hightower, Superintendent*

SCHOOL YEAR \_\_\_\_\_ GRADE \_\_\_\_\_ SCHOOL \_\_\_\_\_

**DAY EDUCATIONAL FIELD TRIP  
MEDICAL AUTHORIZATION FORM**

Student's Name \_\_\_\_\_

**EMERGENCY PHONE NUMBERS:**

Day: Father \_\_\_\_\_ Mother \_\_\_\_\_ Friend \_\_\_\_\_  
Evening/Night: Home \_\_\_\_\_ Other \_\_\_\_\_

**MEDICATION INFORMATION:**

1. Is student taking medication on a regular basis? Yes  No

Name of medication \_\_\_\_\_

Dosage \_\_\_\_\_

Reason for medication \_\_\_\_\_

2. Is your child allergic to any medications? Yes  No   
If yes, which? \_\_\_\_\_

3. When was your child's last tetanus shot? Date \_\_\_\_\_

4. Are there any medical or physical problems of which we need be aware? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. If given a preference, what hospital would you like your child taken for treatment in the event of a medical emergency? \_\_\_\_\_

In case of emergency and a parent cannot be reached by phone, I authorize any teacher/sponsor to obtain medical treatment for my son/daughter \_\_\_\_\_  
(Child's Name)

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

Name of Insured \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Child's Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

I understand that as the parent/guardian of the above-named student, I am responsible for medical expenses incurred. I certify that the above information is accurate and complete and is required for my child to participate in the field trip.

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

Parent's Signature \_\_\_\_\_