ORCHARD PARK CENTRAL SCHOOL DISTRICT
FIELD TRIP PERMISSION SLIP/MEDICAL INFORMATION

STUDENT INFORMATION

_____ _____
Name (last name, first name) Grade

_____ _____
HmRm Home Phone #

PARTCIPATING CLASS/CLUB

School: OPHS

Club/Class: Class of 2026

Chaperone(s): HS Counselors/Teachers

_____

TRIP INFORMATION

Buffalo Convention Center
Destination

3/19/2025
Departure Date
Su Mo Tu We Th Fr Sa
Circle One

Time 9:45 AM/PM

3/19/2025
Return Date
Su Mo Tu We Th Fr Sa
Circle One

Time 12:00 AM/PM

Must be Turned in By: Friday, 2/28/2025

PERMISSION AND MEDICAL STATEMENT

The above named student has my permission to attend and participate in this field trip as part of his/her school experience. Please check ONE of the boxes below:

☐ To the best of my knowledge, the child mentions above is free from any medical problems that could cause difficulty on this field trip.

☐ My child has a medical condition that might cause a problem on this field trip. In the event of an emergency, I hereby directed the advisor on this trip to handle the problem in accordance with my Directions (Describe the problem and any direction on page 2 of this form.)

_____
Signature Parent/Guardian

EMERGENCY CONTACT INFORMATION

_____ _____ _____
Primary Contact Name *Phone Number* *Relationship to Student*

_____ _____ _____
Secondary Contact Name *Phone Number* *Relationship to Student*

Every college will have hand-held scanners to quickly obtain students' information (email, major, etc.) Students must register and receive a mobile barcode in order for colleges to scan the information. Please use the QR code or this link to register:

https://www.nacacattend.org/24buffalo/begin

(Continued)

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Medical Consent and Authorization of Medication in School and School Activities

To be completed by the parent/guardian:

I request that my child _____, child DOB _____, child grade _____, receive the medication as indicated below.

The medication is to be personally deliver by me (parent/guardian) in the original labeled pharmacy contain stating the specific name of the medication and dispensing order.

_____ _____ _____
Parent/Guardian Home Phone Parent/Guardian Cell Phone Parent/Guardian Work Phone

MEDICATION NAME	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISISTRATION

Physician's Name: _____ Physician's Phone Number: _____

The following medical problems should be noted (please include allergies, respiratory ailments, or any other conditions that may impede your child's ability to participate in this trip.)

_____

_____

_____

_____ _____

Parent/Guardian Signature **Parent/Guardian Name (Print)**

Fill out the following for Overnight Field Trip ONLY.

Place: _____ Address: _____

Departure Date: _____ Return Date: _____ Transportation: _____

Teacher(s)/Advisor(s) in charge of Trip: _____

_____

Adult Chaperones: _____

Student Medical Insurance Company/Coverage _____

Policy or ID number _____