

Title Overnight Field Trip - Statement of Responsibility

Group: Seniors **Destination:** Camp Omega, Waterville, MN **Dates:** 8/23/23-8/24/23

For parents:

I give permission for my son/daughter to participate in this trip and I have read and understand all the information and rules provided. I understand that Concordia Academy will provide 5 adult chaperones who will carry out adequate and appropriate supervision during the trip and whose primary responsibility it is to keep the students safe while traveling. I also understand that unanticipated situations can arise which are not reasonably in the control of the supervising adults. (initial)_____

I have completed the medical release form and have listed all medications my child is currently prescribed. I understand that students may not carry prescription medications. I will provide medications needed for the trip in the original container with the dosage listed to the medical coordinator who will make sure my child receives the medication as prescribed. In the case of inhalers and emergency medication (such as EpiPen, Glucagon, Diastat), my student will carry those with them at all times. (It is recommended that the adult medical chaperone is provided with and carries a duplicate set in case of emergency.) (initial)_____

I understand that students are not to carry complete packages of over-the-counter (OTC) medication in their luggage or bags. I give permission for my child to request OTC medication as needed from the medical coordinator. This includes pain reliever, cough medicine, cold and allergy relief, and digestive aids. (initial)_____

or No, please do not give my child the following OTC med: _____ (initial)_____

For students and parents:

I have read, understand, and agree to abide by the rules and behavior expectations for this trip. I will be accountable to my classmates and adult chaperones and will follow the itinerary given. I understand that Concordia Academy’s policies as outlined in the Student Handbook extend into this trip as a school sponsored event. (initial)_____

I understand that the use and/or possession of controlled substances and weapons will result in immediate dismissal from the trip on the first available trip home, unchaperoned, and at student’s expense. Subsequent discipline will follow school policy as well as Minnesota State High School League consequences. (initial)_____

Date _____

Parent/Guardian Signature _____

Student Signature _____

Concordia Academy

2400 North Dale Street, Roseville, MN 55113 Ph: 651-484-8429

Title Overnight Field Trip – Student Medical Treatment Information and Permission

*All information will be kept private, used only for emergency, and destroyed upon return from the trip.

Student's name _____ Date of birth _____

Address _____ Phone (____) _____

City _____ Zip _____

Parent/Guardian 1 _____

Home # _____ Cell # _____

Parent/Guardian 2 _____

Home # _____ Cell# _____

Name of emergency contact _____ (____) _____

Primary Health Care Provider _____ Ins. Policy # _____

Name of Policy holder _____

Please attach photocopy of both sides of student insurance card.

Medical Information

Any known allergies (including drug allergies or severe allergies to animals, foods or other substances)?

no / yes. If yes, describe _____

Date of last tetanus shot _____

Medication student is presently taking _____

Dosage _____

Reason _____

***NOTE: All prescription and OTC medication must be in original container with dosage information.**

List any physical factors that might affect student's activity or would be necessary for a physician to know when caring for your child. _____

Parental Permission

If an emergency arises, it might be necessary to seek care for your child before staff can contact you. Such care can be provided only if you sign the authorization below. Either the authorization or a notarized statement of the reason for not allowing it should accompany this health form.

In case of minor illness or injury, I, _____, parent or guardian of _____, give my permission for the supervisor of my child to administer necessary treatment and/or first aid.

In case of emergency, I hereby authorize the official representative of my child's school or the person in charge of the program to permit a physician/hospital to administer emergency or surgical care, and I further authorize any licensed physician, medical facility or trained emergency technician to administer emergency or surgical care.

Signature of parent or guardian

Date