City Academy School
Shaw Nature Reserve Overnight Trip

PLEASE return this form to:
Mrs. Ann Luciani – Grade 3 & 4 Science Specialist

_____
Child's Name (Please print)

_____
Parent or Guardian's Name and Telephone Number (include work, home and cell) (Please print)

_____

SECTION 1: PARTICIPATION AUTHORIZATION FOR A MINOR

The overnight trip to Shaw Nature Reserve will result in visiting several wooded sites at the reserve. We must have your written permission for your child to participate in these activities. Activities may include: hiking, walking, exploring, and sleeping in cabins. The child named above has my permission to participate in these activities.

SECTION 2: TEACHER CHAPERONES

For your child's safety, this trip will be chaperoned by members of the City Academy Faculty which includes the grade level advisors. All questions about the trip should be directed towards Ann Luciani (Grade 3 & 4 Science Specialist) via email. A letter has already been sent home explaining the trip.

SECTION 3: MEDICAL INFORMATION

Please understand that the following information is vital for our staff to know in order to make wise decisions regarding the well being of your child.

Name: _____ **Birth date:** ____/_____/_____

Last First M.I. (Month/day/year)

Address: _____ **City:** _____ **State:** _____ **Zip:** ____

Male ____ **Female** ____ **Name child prefers to be addressed as:** _____

Parent or Guardian: _____ **Relationship:** _____

Phone Number: Home (____) _____-_____ **Cell** (____) _____-_____ **Business** (____) _____-____

If we cannot reach you, whom can we notify? _____

Phone Number: Home (____) _____-_____ **Business** (____) _____-_____

Family Physician: _____ **Office Number:** (____) _____-_____

Is this youth insured under a family health insurance policy? No ____ Yes ____ if yes, provide the following:

Health Insurance Company:_____ **Policy Number:**_____
Policy Holder's Name:_____ **Group Number:**_____
Member ID:_____ **Insurance Phone Number:**_____

Health History *(Check appropriate items and give approximate date where applicable)*

Bronchitis	Constipation	Sore throats
Convulsions	Frequent Colds	Stomach upsets
Diabetes	Headaches	Other:_____
Ear Infection	Hypertension	
Epilepsy	Hypoglycemia (low blood sugar)	
Fainting	Sinusitis	

Any known respiratory difficulties or allergies? (*Please list reaction time if known.*)

Animal Fur _____ **Hay Fever** _____

Asthma _____ **Penicillin** _____

Bee or Insect Stings _____ **Poison Ivy, Oak, Sumac** _____

Foods (specify) _____ **Other** _____

Any physical limitations? *(Please describe)*

_____

_____

Please list and describe any conditions currently being treated and/or medications currently being taken.

_____

_____

Any special dietary requirements?

_____

SECTION 4: MEDICATION NEEDS

If a student requires medication of any kind, it is the sole responsibility of the parent to provide the medication and detailed instructions to the student's chaperones on the day of departure. If the medication is located at school, it is still the responsibility of the parent to make sure this is retrieved prior to the overnight, along with instructions, to the chaperones.

Please check appropriate response.

☐ My child will be responsible for holding onto and administering his/her own medication.

☐ I would like a staff member (from school or group) to hold on to my child's medication and remind her/him to take it at the appropriate time.

Please fill out the following for medication to be received during an Educational Program.

Name of medication	Specific time(s)	Dose(s)

I give permission for my child to receive the above medication as directed.

SECTION 5: MEDICAL RELEASE

- I understand that parts of the Overnight Trip may be physically demanding.
- I affirm that the youth named below is in good health, and that he/she is not under a physician's care for any condition that might endanger his/her safety or the safety of other participants, or in any way limit his/her ability to participate in any of the for which he/she is registered.
- I grant permission to the City Academy Staff to secure medical aid and/or hospital services deemed necessary for the individual named on this form, in the event he/she should sustain an injury or illness while participating in the Program.
- I authorize emergency medical responders and the doctor and hospital to which my child may be brought to perform any emergency procedure or operation, to give treatment, injections, and the administration of any anesthetic to my child.
- I have indicated any medical information the City Academy Staff or medical treatment providers may wish to consider in treating any illness or injury sustained by my child in the course of participating in the activities of the Spring Break Trip.

Signature: _____ Date: _____

Printed Name: _____

Address _____ Phone _____