

# FIELD TRIP PERMISSION FORM – In County & Out of County – Day or Overnight



**Form Instructions:** (1) Use one form per trip. (2) Teacher must complete the “Field Trip information” section. (3) Print one form for each student, (4) Send form home for parent(s) to complete all remaining sections, (5) Ensure there is a completed form for each student attending field trip, (6) Form must be available at field trip location.

STUDENT INFORMATION:			
STUDENT’S LAST NAME	STUDENT’S FIRST NAME	STUDENT’S BIRTH DATE (MM/DD/YYYY)	
STUDENT’S ADDRESS	CITY, STATE, & ZIP CODE	STUDENT’S CELL PHONE	
SCHOOL NAME	CORRESPONDING CLASS/SUBJECT	CURRENT GRADE LEVEL	
HORIZON HIGH SCHOOL	HORIZON FOOTBALL		
FIELD TRIP INFORMATION:			
FIELD TRIP DESTINATION	DATE(S) OF FIELD TRIP	MEANS OF TRANSPORTATION	
SAN DIEGO STATE UNIVERSITY	June 12–15, 2026	VANS	
DEPARTURE TIME FROM SCHOOL	ESTIMATED RETURN TIME TO SCHOOL	COST OF TRIP	
9:00am	7:00pm	0	
EMERGENCY CONTACT INFORMATION:			
PARENT/GUARDIAN TO CONTACT	PHONE NUMBER	RELATIONSHIP TO STUDENT	PHONE TYPE <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK
ALTERNATE EMERGENCY CONTACT	PHONE NUMBER	RELATIONSHIP TO STUDENT	PHONE TYPE <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK
MEDICAL INFORMATION:			
NAME OF HEALTHCARE PROVIDER	HEALTHCARE PROVIDER PHONE	MEDICAL INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO	
HEALTH INSURANCE NAME & PLAN	POLICY NUMBER	GROUP NUMBER	
DATE OF LAST TETANUS SHOT	KNOWN ALLERGIES (LIST ALLERGIES TO MEDICATIONS AND FOODS. IF NONE, PLEASE INDICATE SO.)		
SPECIAL MEDICAL CONSIDERATIONS. If NONE, so indicate.			
MEDITATIONS: My child takes the following daily and/or emergency medication(s). If NONE, so indicate.			
I understand that it is my responsibility to contact the school nurse no less than 48 hours prior to the field trip to facilitate the completion of all corresponding medication forms as well as the transfer of all accompanying medications.			
WATER HAZARD NOTICE:			
Water facility usage is permissible while traveling if activity is staffed with a certified lifeguard on duty. There are inherent risks in using water facilities. If you choose to have your child participate, you accept those risks. Please mark one of the boxes below to indicate that you are aware of your child’s ability to swim or to be near any body of water. By signing this permission slip, you are stating that you accept the risks in using water facilities.			
My child has the appropriate level of swimming skills to safely participate in all water related activities. <input type="checkbox"/> YES <input type="checkbox"/> NO			
ACKNOWLEDGMENT OF POTENTIAL RISKS & LIABILITY DISCLAIMER:			
<b>Acknowledgment of Risk:</b> I understand and acknowledge that any field trip carries some degree of risk whereby participation in the event could potentially result in injury, illness, and even death. I understand and acknowledge that as a condition of the student’s participation in this field trip, I as the parent/guardian agree to indemnify, defend, and hold harmless to the fullest extent permitted by Arizona law, the Paradise Valley Unified School District and its schools, officers, employees, agents, representatives, and volunteers from and against any and all liability including injuries, illnesses, and damages, as well as any other claims, losses, and defense costs, of any kind or nature, resulting from or in connection with this field trip.			
<b>Medical Insurance:</b> I understand and acknowledge that the Paradise Valley School District (PVUSD) does not carry health, medical, or disability insurance coverage for its students and therefore any injuries and/or illnesses and subsequent medical expenses that occur through the participation or attendance of this event shall be covered by the parent’s/guardian’s own insurance plan or other means of personal payment.			
AUTHORIZATION:			
<b>Authorization:</b> I permit the above-named student to attend and participate in the field trip that has been scheduled. If any illness or injury occurs during this trip, I authorize school representatives to obtain emergency treatment for the above student at the closest medical facility unless instructed otherwise by paramedics or according to the special instructions listed above. I understand that the school assumes no responsibility for injuries or illnesses other than to exercise prudent supervision. <input type="checkbox"/> YES <input type="checkbox"/> NO			
PLEASE CONTACT ME IF A PARENT/GUARDIAN VOLUNTEER IS NEEDED. <input type="checkbox"/> YES <input type="checkbox"/> NO			

Signature of a parent or legal guardian

Date of signature

**OUT-OF-COUNTY (DAY) OR OVERNIGHT FIELD TRIP OVER-THE-COUNTER MEDICATION RECORD**  
**EXCURSIÓN FUERA DEL CONDADO CON ESTADÍA DE DÍA O POR LA NOCHE - REGISTRO DE**  
**MEDICAMENTOS DE VENTA LIBRE**



Student Name *[Nombre del alumno]* \_\_\_\_\_ Teacher *[Maestro]* **TYSON DITMORE**

Supervising Teacher *[Maestro supervisor]* \_\_\_\_\_ Bus Number *[No. De autobús]* \_\_\_\_\_ Room # *[Salón]* \_\_\_\_\_ Grade *[Grado]* \_\_\_\_\_

In case of minor injury or illness during the out-of-county (day) or overnight field trip, I authorize the accompanying medical personnel or principal designated supervising teacher to be my agent to give my child the **age-appropriate dosage as directed on the packaging of over-the-counter medication indicated below.** I understand alternate methods of care will be used before medication is given (i.e., eating, hydration, resting, etc.). *[En caso de alguna lesión o enfermedad leve durante la excursión con estadía por la noche, autorizo al personal médico acompañante, o maestro supervisor designado por el director, para suministrar a mi hijo la dosis apropiada para su edad, indicada en el envase del medicamento de venta libre mencionado más adelante. Entiendo que se usarán métodos alternos de cuidado, antes de suministrar el medicamento (p. ej: comer, tomar agua, descansar, etc.).]*

I agree to, and do hereby hold the district and its employees harmless from any and all claims, demands, causes of actions, liability, or loss of any sort, because of or arising out of acts or omissions with respect to this medication. *[Convento y por la presente libero de cualquier responsabilidad al distrito escolar y sus empleados por todos y cada uno de los reclamos, demandas, procesos de acción legal, obligaciones o pérdidas de cualquier clase debido a, o como resultado de acciones u omisiones con respecto a este medicamento.]*

**PLEASE INITIAL NEXT TO THE MEDICATION(S) YOU ARE AUTHORIZING AND DESIGNATE SYMPTOM(S)\* FOR ADMINISTRATION**

Regardless of a venue medication list (if any), I understand that **ONLY** the over-the-counter medications listed below will be available.

*ESCRIBA SUS INICIALES EN EL CUADRO CORRESPONDIENTE AL(LOS) MEDICAMENTO(S) QUE AUTORIZA E INDIQUE LOS SÍNTOMAS DE SU HIJO(A) PARA LOS CUALES SE DEBE DISPENSAR. Entiendo que SOLAMENTE estarán disponibles los siguientes medicamentos de venta libre, sin tener en cuenta cualquier lista de medicamentos (si la hay) de una sede de excursión.*

<u>Parent Initials</u>	<u>Medication</u>	<u>Symptoms for Administration*</u> <b>*INFORMATION REQUIRED TO BE ABLE TO ADMINISTER</b>
→	Tylenol® (Acetaminophen), 80mg, 325mg, 500mg tablet(s)/suspension <i>Tylenol® (Acetaminophen), tableta de 80, 325 o 500 mgs o suspensión</i>	
→	Motrin®/Advil® (Ibuprofen), 100mg, 200mg tablet(s)/suspension <i>Motrin®/Advil® (Ibuprofen), tableta de 100 o 200 mgs o suspensión</i>	
→	Tums® (Calcium Carbonate), 500mg tablet <i>Tums® (Calcium Carbonate), tableta de 500mg</i>	
→	Dramamine® (Dimenhydrinate), 50mg tablet <i>Dramamine® (Dimenhydrinate), tableta de 50mg</i>	
→	Calamine Lotion (applied topically as needed) <i>Loción Calamine (aplicación local según sea necesario)</i>	
→	Benadryl™ (Diphenhydramine), 12.5mg/5ml suspension/25mg tablet(s)/suspension <i>Benadryl™ (Diphenhydramine), 12.5mg/5ml suspensión 25mg tableta</i>	

Signature of Parent/Guardian *[Firma de un padre de familia o tutor legal]* \_\_\_\_\_ Date *[Fecha]* \_\_\_\_\_

**To be Completed by Administrator of Out-of-County Day or Overnight Field Trip Over-the-Counter Medication(s)**  
*Esta sección la llena el encargado de administrar medicamentos durante una excursión fuera del condado con estadía de día o por la noche*

**Medication Record**

OTC Medication Given	Date	Time	Given By	OTC Medication Given	Date	Time	Given By

Medical Professional/Supervising Teacher Signature

Initials