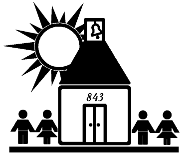

Lincoln-Way Area Special Education
Joint Agreement District 843

601 Willow Street
Frankfort, IL 60423
Phone: 815.806.4600
Fax: 815.806.4601

FIELD TRIP PERMISSION RELEASE

Attending School: ______________________________

Grade Level/Subject Area: ______________________________

Field Trip
- Date/Time: ______________________________
- Location: ______________________________
- Rationale: ______________________________
- Transportation: ______________________________
- Fee: ______________________________
- Medical Information: ______________________________

School Medication Authorization Form – If the district School Medication Authorization Form is on file the PARENT/GUARDIAN SHOULD CONTACT THE SCHOOL NURSE to assure that the field trip supervisor will be alerted to the student's needs. DO NOT SEND MEDICATION INDEPENDENTLY.

Supplemental Medication – If you have normally scheduled medication for your child other than school times and the field trip disrupts his/her routine, please CONTACT THE SCHOOL NURSE TO DISCUSS THE PROCEDURES TO BE FOLLOWED AND BE PREPARED TO PROVIDE THE FOLLOWING INFORMATION:

- Student's name
- Prescription number
- Medication name/dosage
- Administration route and/or other directions
- Date and refill
- Licensed prescriber's name
- Pharmacy name, address, and phone number
- Name or initials of pharmacist

If bringing over-the-counter medication, the container is to be affixed with the manufacturer's original label indicating the ingredients and the student's name.

Reminder of any allergic reactions:

____

____

As parent/guardian of ______________________________ grade ____________
I hereby grant permission to the above field trip sponsored by District 843 and understand the information supplied regarding such trip.

____
Parent/Guardian signature

Please send this form and payment to your child's teacher by: ______________________________