Summer Aviation Camp Project GAP

/ FIELD TRIP
PERMISSION SLIP / EMERGENCY FORM

Please complete this form that will accompany your child on the field trip. This information is necessary should we need to contact you while we are away from the school. No student will be allowed to participate without this form being completed and signed by the parent or guardian. The information on this form is considered confidential and will accompany the school trip leader/nurse on the trip.

Permission is granted for:

(Name of Student) PLEASE PRINT

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name:

Address:

Phone #: Emergency Phone #:

Please provide the information requested below, as it may be needed in case of an emergency. This information does not modify the information on the emergency card.
Student's Date of Birth

Allergies:

Conditions requiring special consideration (medical/physical):

Does your student require: (A) **Epipen** Yes ☐ No ☐ (B) **Inhaler** Yes ☐ No ☐ (C) **ANY MEDICATION CURRENTLY TAKEN:** (Type of medication and time of administration):

Please be sure to speak to 's Nurse before _____ **[DATE]** regarding any medications or special needs your student may have. THIS INFORMATION WILL REMAIN CONFIDENTIAL. IT WILL STAY WITH THE SCHOOL TRIP LEADER/NURSE ON THE DAY OF THE TRIP. CONTACT INFORMATION FOR DAY OF FIELD TRIP ONLY:

Primary contact name Relationship to student:

Phone #: Work Phone #: Cell Phone/Pager #:

Secondary contact name Relationship to student:

Phone #: Work Phone #: Cell Phone/Pager #:

Student's Physician: Phone #:

Student's Dentist: Phone #:

TO ANY DOCTOR OR HOSPITAL: I hereby authorize the release of my child's pertinent medical information to the appropriate professional staff. I give permission to the physician or hospital to secure treatment for him/her and to order medications, injections, anesthesia, or surgery for my child, as named above, in case of emergency. The signature below constitutes authorization to perform any necessary treatment for my child during this field trip.

HEALTH INSURANCE INFORMATION:

Company Name: Policy #: Group #:

Parent/Guardian Name: Date:

(PLEASE PRINT)

Parent/Guardian Signature:

Summer Aviation Camp

Project GAP

1704 Weeksville Road, Elizabeth City, NC 27909

PH (252) 335-3355 FAX (252) 335- 3502

https://www.ecsu.edu/current-students/student-affairs/project-gap/untitled.html

CHILD'S NAME_____

ADDRESS_____

PHOTOGRAPHS

I hereby grant permission for my child to be photographed by the staff at Project GAP Summer Aviation Camp.

for the following purposes:

_____ Camp Activities _____ Camp Publications _____ Project GAP/ ECSU Website

I understand that no photographs of my child will be released to the media without my written consent.

Parent Signature_____ Date _____

AUTHORIZATION FOR SUNSCREEN AND FIRST AID

I authorize Project GAP/ ECSU to administer the following non-prescription.

medication to the above-named child when necessary:

_____ Sunscreen _____ First Aid Cream

Parent Signature_____ Date _____

AUTHORIZATION & CONSENT FORM

I understand that every effort will be made to contact me in the event of an emergency.

requiring medical attention for my child_____.

However, if I cannot be reached, I hereby authorize Project GAP/ ECSU to

transport my child to the nearest hospital and to secure for my child the necessary medical treatment.

I understand the staff members in university are trained in the basics of First Aid and I

authorize them to give my child first aid when appropriate.

_____ _____

Parent/Guardian Signature Date

_____

Telephone #'s of Parent/Guardian in case of an emergency – Day Tel #'s

EMERGENCY RELEASE FORM

In case of an emergency, give the names of persons who can be called to pick-up your child in the event that a parent cannot be reached.

Name_____ Relationship to child_____

Address_____ Tel #_____

Name_____ Relationship to child_____

Address_____ Tel #_____

_____ _____

(Doctor/s Name, Address, Phone)

EMERGENCY CONTACT PERSON(S)

1._____

(Name, Address, Phone)

2._____

ALLERGIES, CHRONIC HEALTH CONDITION: _____

_____

____

INSURANCE INFORMATION (Optional)

Company Name_____Policy #_____

In efforts to better serve you, please list special dietary needs or food allergies below.

_____

_____

_____

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