# TRIP INFORMATION

THE SCHOOL DISTRICT OF PHILADELPHIA

**PARENTAL PERMISSION**

|  |  |  |  |
| --- | --- | --- | --- |
| SchoolMcClure School | School Phone215.400.3870 | Grade /RoomGrades 2-3 | Date Prepared1.24.2020 |
| Tea cher | DestinationAcademy of Natural Sciences 1900 Benjamin Franklin Parkway, Phila |

Educ ational Purpose of Trip

To provide students with an experience aligned to science standards.

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Trip1.28.2020 | Leave Time9:30 am | Return Time1:30 pm | Trip Itinerary (summary) |
| Method of TransportationYellow Bus Service | Cost to Student8Free $  | Student LunchBrin g | Buy | 8Provided | Not Needed |

Please complete and deta ch the bottom part of this form and return to tea cher

# STUDENT INFORMATION

Name of student:

# PARENT/ GUARDIAN INFORMATION

I.D.#: Date of Birth:

* 1. Parent/ Guardian: Home Address:

Home Phone: Work Phone: Cell Phone:

* 1. Parent/ Guardian: Home Address:

Home Phone: Work Phone: Cell Phone:

Student lives with ( check all that applies): Father Mother Guardian

# EMERGENCY CONTACTS

If the parents/ guardians c annot be rea ched, the school will c all the people liste d below. The people liste d

below should be responsible individuals who c an: 1) give permission to administer health c are; 2) pick up your child if your child is ill; 3) have the authority to speak on behalf of the parents or legal guardians.

Name: Home Phone: Work Phone: Cell Phone:

Name: Home Phone: Work Phone: Cell Phone:

# HEALTH INFORMATION

If permission is granted, please provide the following medic al information or if your child does not have any of the health conditions liste d below, please write *“none”*.

Medic ation/s being taken by student: Allergies to foods, drinks, insect bites, medic ations, other: Other medic al information: Physician’s Name: Phone: Medic al/Hospital Insurance: Group: Type:

**I have read the trip information to:** Academy of Natural Sciences 1900 Benjamin Franklin **on** 1.28.2020 .

# Check one: my child

**may**

# may not go on this trip

I understand that in c ase of any emergency requiring medic al treatment, every effort will be made to rea ch one of the people liste d above. If none of these people c an be conta cted, I authorize the school to give

consent to treatment as deemed necessary by emergency responders.

Print Name of Parent/s or Guardian/s: Signature of Parent/s or Guardian/s: Date: ***A copy of this form is to be kept on file until the end of the school year.***

EH-80 Parental Permission (Rev. 10/06) - THESCHOOL DISTRICT OF PHILADELPHIA