

**Central Regional School District  
Bayville, NJ**

**Permission for Trips**

My child \_\_\_\_\_ has my permission to participate with the following  
(child's Name)

group \_\_\_\_\_ on a field trip with \_\_\_\_\_  
(club, team, activity, etc) (advisors)

going to \_\_\_\_\_  
(location, including town & state)

leaving on \_\_\_\_\_ Cost of trip \_\_\_\_\_  
(date) (time)

returning on \_\_\_\_\_  
(date) (time)

Additional Info \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Student Cell \_\_\_\_\_ Student Homeroom \_\_\_\_\_

Friend(s) on this trip: \_\_\_\_\_

This is to certify that my child named above has my permission to participate in the specified trip and to travel off school grounds with the group for the purpose of participating in the group's activities and events. I understand that, if circumstances warrant, including in case of disciplinary infractions, I may be contacted and requested to transport my child home prior to the end of the trip.

I knowingly and voluntarily agree to waive any and all claims for liability, loss, injury, damages, or expenses which my child and I may have against the Central Regional Board of Education, collectively and individually, and its agents, employees and chaperones resulting in any way from participation in the above activity and related transportation.

Students Trip Medical Release and Health Information

In case your child may require emergency medical services while on an off-campus trip, we ask that you complete the following information:

Parent/Guardian Name \_\_\_\_\_

Home # \_\_\_\_\_ Business # \_\_\_\_\_ Cell # \_\_\_\_\_

If Parent/Guardian can not be reached, in case of emergency please call:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Health Insurance Provider \_\_\_\_\_

ID # \_\_\_\_\_

Any health factors/medical conditions of which chaperones should be aware (please note that this does not include, nor are you required to provide information regarding HIV and AIDS).

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\*Medications being taken on trip \_\_\_\_\_

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**\*MEDICATION/HEALTH ADVISORY:** The school nurse does not accompany all trips off campus. Please contact the school nurse upon receipt of this permission form if there are any health or medical issues concerning your child. Please be aware that any medications being taken on this or any other school-sponsored trip, including over-the-counter medication, such as Tylenol, Dramamine, allergy medications, etc., must be approved by the school nurse **prior** to the trip, in accordance with State law and Board policy. Please contact the school nurse directly, will in advance of the trip to obtain the approval of any medication, and/or to determine by who they are to be administered.

I have read and understand the above policy and I authorize the release of the information contained in this form to the responsible advisor/trip chaperone. In the event of a medical emergency, I authorize the Central Regional School District and its member in charge of my child, to obtain all necessary medical care and further authorize any licensed physician and/or medical personnel to render all necessary medical treatment (including drug and alcohol testing). Results which include urine analysis, must include testing for: (cut off values) Amphetamine (1000 ng/ml), Barbiturates (20 ng/ml), Benzodiazepines (300 ng/ml), Cannabinoid (10 ng/ml), Cocaine (Metab.) (300 ng/ml), Opiates (300 ng/ml), Phencyclidine (25 ng/ml), and Alcohol, are to be released to the school designee.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_