

TRIP INFORMATION

PARENTAL PERMISSION

School Arts Academy at Benjamin Rush	School Phone 215-281-2603	Grade/Room 9-11	Date Prepared 1/6/2011
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Teacher Todd Corabi: Girls Soccer Coach	Destination Varies: Interscholastic Athletics: See attached Schedule
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Educational Purpose of Trip
To help promote physical, intellectual, social, emotional and spiritual wellness through interscholastic athletic competition

Date of Trip Varies: See attached schedule	Leave Time 1:30-1:45	Return Time 5:15pm	Trip Itinerary (summary) See attached Itinerary
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Method of Transportation School buses supplied by Office of Athletics	Cost to Student <input checked="" type="checkbox"/> Free \$_____	Student Lunch <input type="checkbox"/> Bring <input type="checkbox"/> Buy <input type="checkbox"/> Provided <input checked="" type="checkbox"/> Not Needed
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Please complete and detach the bottom part of this form and return to teacher

STUDENT INFORMATION

Name of student: _____ I.D.#: _____ Date of Birth: _____

PARENT/GUARDIAN INFORMATION

1. Parent/Guardian: _____ Home Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

2. 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 cannot be reached, the school will call the people listed below. The people listed below should be responsible individuals who can: 1) give permission to administer health care; 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: _____ Name: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

HEALTH INFORMATION

If permission is granted, please provide the following medical information or if your child does not have any of the health conditions listed below, please write "none".

Medication/s being taken by student: _____

Allergies to foods, drinks, insect bites, medications, other: _____

Other medical information: _____

Physician's Name: _____ Phone: _____

Medical/Hospital Insurance: _____ Group: _____ Type: _____

I have read the trip information to: _____ on _____.

Check one: my child may may not go on this trip

I understand that in case of any emergency requiring medical treatment, every effort will be made to reach one of the people listed above. If none of these people can be contacted, 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.