

## FIELD TRIP PERMISSION SLIP AND MEDICATION(S)

St. Stephen's Episcopal School, Houston, 1800 Sul Ross Houston, TX 77098

Name of Participant				
Age of Participant				
Group Description or				
Homeroom				
ACTIVITY				
Date and Time of				
Activity				
Location of Activity				
Description of				
Activity				
Transportation				
to/from Activity				
EMERGENCY CONTA	СТ			
Name of Parent /				
Guardian				
Mobile Phone				
Work Phone				
Home Phone				
ALTERNATE EMERG	ENCY CONTACT			
Name of Alternate				
Emergency Contact				
Mobile Phone				
Work Phone				
Home Phone				
MEDICAL CONDITIO	N(S)			
Teachers and chaperones of the Activity need to be aware that the participant has the following				
medical condition(s) (e.g., asthma, diabetes, allergies). Please attach an additional page if necessary.				

#### RELEASE, INDEMNITY, AND MEDICAL TREATMENT AUTHORIZATION

This is to certify that my child\* (named above) has my permission to participate in the Activity, as specified above. I understand that my child\*/I will be away from the campus of St. Stephen's Episcopal School, Houston (the "School") during this Activity. Furthermore, I understand that this Activity is being undertaken under the auspices of the School, and I understand that teachers will supervise the Activity



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and that chaperones will assist the Group. I certify that my child\* is/I am in good health and can participate in the Activity with the Group.

I understand it is my sole responsibility to decide on and implement any activity restrictions which I deem necessary for my child's\*/my personal welfare and safety.

AS ADDITIONAL CONSIDERATION FOR MY CHILD\*/ME BEING PERMITTED TO PARTICIPATE IN THE ACTIVITY, I, INDIVIDUALLY AND ON BEHALF OF MY CHILD\*, HEREBY RELEASE, DISCHARGE, INDEMNIFY, DEFEND, AND HOLD HARMLESS <u>ST. STEPHEN'S EPISCOPAL</u> <u>SCHOOL, HOUSTON AND ST. STEPHEN'S EPISCOPAL CHURCH, AND THEIR RESPECTIVE</u> <u>SHAREHOLDERS, TRUSTEES, MEMBERS OF THE VESTRY, DIRECTORS, OFFICERS,</u> <u>EMPLOYEES, AGENTS, AFFILIATES, VOLUNTEERS, CHAPERONES, AND REPRESENTATIVES</u> (ALL SUCH ENTITIES AND INDIVIDUALS BEING REFERRED TO COLLECTIVELY HEREINAFTER AS THE "RELEASED PARTIES") FROM ANY AND ALL CLAIMS ARISING OUT OF OR IN ANY WAY RELATED TO MY CHILD'S\*/MY PRESENCE AT THE LOCATION OF THE ACTIVITY AND/OR MY CHILD'S\*/MY PARTICIPATION IN THE ACTIVITY, WHETHER CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE (WHETHER SOLE, JOINT, OR CONCURRENT) OR GROSS NEGLIGENCE OF THE RELEASED PARTIES.

I have read and voluntarily signed this Release and Indemnity, and I further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made. I understand this document includes a full and final release and indemnification of all claims.

In case of accidents or illness, I authorize St. Stephen's Episcopal School, Houston to request and obtain necessary medical services for my child\*/me should an emergency arise as determined by the teachers and/or chaperones. I acknowledge and understand that the cost of any such medical care is my financial responsibility and/or that of my legal guardian, if any.

\*Or ward if and as applicable

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_



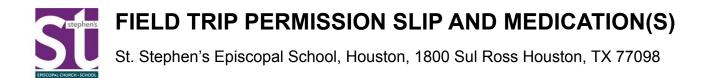
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Student's Name				
Age of Student				
Name of Teacher				
Homeroom Class				
Will your child be	YES. Please use one form for each medication (prescription or			
taking medication	over-the-counter).			
during the Activity?	NO. Please sign below.			
MEDICAL INFORMAT	ION			
Prescribing Physician's Name				
Diagnosis				
Name of Medication				
Length of time				
student has been				
taking the Medication				
Possible side effects				
from the Medication				
DOSAGE AND SCHE	DULE			
Dosage				
Medication to be	As Needed			
administered	On the Dates and Times Below			
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_



### **Medication Dispensation Record**

Student's Name	
Name of Teacher	
Homeroom Class	
Medication	
Dosage	

Date	Time	Dosage	Initials