

# Annual Field Trip Release/Emergency Medical Form

Dayspring Christian Academy  
P.O. Drawer 909  
Blacksburg, VA 24063-0909

School Year: 2023-2024  
540-552-7777

This form will be on file at the school office for the current school year. **An additional permission to participate form will be sent home prior to each off-campus trip.**

I give permission for \_\_\_\_\_, grade \_\_\_\_\_, to participate in all sports and school sponsored trips away from the school premises throughout the current school year. Students will be accompanied by a teacher and will be under adequate supervision.

I understand that I will be given at least 48 hours notice of all trips away from the school premises. I further understand that revoking permission for a specific field trip is to be appropriately accomplished with a note delivered at least one day prior to the trip to the school administrator or person(s) directed by the administration as responsible for conducting the activity. Lastly, it is understood that revoking permission payment of any costs associated with the activity unless in the judgment of the administrator special circumstances prevail.

Although the school desires to provide a safe and enjoyable time for all students, accidents can still happen. I/we understand that there are risks/dangers involved with participation in off-campus trips and their associated activities. In consideration of my child being allowed to participate in an event, I/we agree to assume responsibility for those ordinary and reasonable risks associated with the travel and activities. I/we agree to hold harmless Dayspring Christian Academy, its affiliated organizations, employees, agents and representatives, including volunteer and other drivers, from any claims of intentional (criminal) misconduct or gross negligence by the school, its employees, or volunteers. If such circumstances are proved in a court of law, I/we acknowledge and agree that the school can assume no financial liability insurance policy in force.

I/we, the parent(s)/legal guardian(s) of the child listed below hereby authorize permission for medical treatment of our child in the event we cannot be reached.

**We prefer to have both parents' signatures, but both are not required.**

\_\_\_\_\_  
Father/Guardian's Signature      Date

\_\_\_\_\_  
Mother/Guardian's Signature      Date

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Name Printed

## **ALTERNATE EMERGENCY CONTACTS:**

**In case of emergency, whom should we contact if we are unable to contact you?**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

# Permission for Medical Treatment

In case of accident, illness or other emergency, I/we request that the school contact me/us. If the school cannot reach a parent/guardian after conscientious effort I/we give permission for school staff to call paramedics or any licensed physician or dentist. If a life-threatening emergency exists I/we give permission for school staff to call paramedics immediately and then contact me/us as soon as possible thereafter.

I/we authorize and consent to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care, which in the best judgment of a licensed physician or dentist is deemed advisable. I/we agree to assume the financial responsibility for expenses incurred as a result of those services being provided. I/we also agree to be financially responsible for emergency medical transportation.

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Home Address \_\_\_\_\_

Allergies \_\_\_\_\_

Date of last Tetanus booster \_\_\_\_\_

Routine or current medications \_\_\_\_\_

Significant medical problems \_\_\_\_\_

Family Physician/pediatrician \_\_\_\_\_ Phone number \_\_\_\_\_

Father's Name \_\_\_\_\_ Home phone \_\_\_\_\_

Cell phone \_\_\_\_\_ Email \_\_\_\_\_

Employer's Name \_\_\_\_\_ Business phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Type: Medical \_\_\_ Dental \_\_\_ HMO/PPO \_\_\_

Subscriber \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Are there any limitations in coverage? \_\_\_\_\_

**(Attach copy of insurance card)**

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell phone \_\_\_\_\_ Email \_\_\_\_\_

Employer's Name \_\_\_\_\_ Business phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Type: Medical \_\_\_ Dental \_\_\_ HMO/PPO \_\_\_

Subscriber \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Are there any limitations in coverage? \_\_\_\_\_

**(Attach copy of insurance card)**

## **PLEASE DO NOT SIGN UNTIL IN THE PRESENCE OF A NOTARY**

Authorization shall remain in effect until August 15, 2024

Parent/guardian signature \_\_\_\_\_ Relationship to student \_\_\_\_\_

(Optional) Parent/guardian signature \_\_\_\_\_ Relationship to student \_\_\_\_\_

Notary signature \_\_\_\_\_ Date \_\_\_\_\_

**Affix Seal Here**