Annual Field Trip Release/Emergency Medical Form

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

School Year: 2024-2025
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, <u>but both are not required</u>.

_____ _____
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 denist 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, 2025

Parent/guardian signature _____ Relationship to student _____

(Optional) Parent/guardian signature _____ Relationship to student _____

Notary signature _____ Date _____

Affix Seal Here