TRINITY ACADEMY

Innovative Classical Learning

Trinity Academy
Lower School Field Trip Permission Slip

Student Name: _____(DOB:)_____

Field Trip Name/Location: _____

Date/Times: _____

I give my child permission to attend the stated field trip. In case of an emergency, I hereby give my permission to the licensed physician and hospital selected by the Trinity Academy representative to secure proper treatment for my child.

_____ _____

Parent Full Name | Date

_____ _____

Parent Cell Phone Contact Number | Parent Signature

_____ _____

Student's Physician | Physician's Contact Number

_____ _____

Medical Insurance Company | Medical Insurance Policy and Group Number(s)

Please identify/describe any allergies or other chronic medical conditions of the student(s) and the appropriate medication/ treatment for the condition. (i.e. asthma/inhaler, diabetes/insulin, bee sting/epi-pen, etc.). Please be sure to provide any of these items directly to the teacher.

SACSCASI Southern Association of Colleges and Schools

NCAIS North Carolina Association of Independent Schools

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