HOLY CROSS
HIGH SCHOOL
587 Oronoke Road • Waterbury, CT 06708-3999 • www.HolyCrossHS-ct.com
203.757.9248 (Phone) • 203.757.3423 (Fax)

STUDENT FIELD TRIP/ACTIVITY REQUEST

I request and authorize that you allow my child _____ to attend the school sponsored field trip/activity as follows:

Trip Destination: _____
From: _____ Until: _____

The teacher/organization sponsoring this activity will provide the student with accurate information regarding the method of transportation, cost (if any), proper attire, and the particulars surrounding the activity.

I understand that this is a school-sponsored trip/activity and that all school rules and regulations are in effect. I further understand that any breach of school rules and regulations or any type of conduct or activity found unacceptable could result in the aforementioned student being sent home and subject to school disciplinary measures.

I know that all possible safety and care will be provided for my child. Therefore, in case of an accident, I will not hold Holy Cross High School and/or its faculty/staff responsible.

If I (parent/guardian) am not available during an emergency, the following individual(s) can be contacted in my absence.

_____

Emergency Contact 1 Phone Relationship

_____

Emergency Contact 1 Phone Relationship

My child and I are insured by the following company:
_____ (policy number _____) which can be reached in an emergency at (800) _____.

I authorize and medical treatment necessary in the event that I cannot be reached,

_____ _____

Parent/Guardian Siganture Date

Phone: (Work) _____ (Home) _____ (Cell) _____

If you have any questions or concerns concerning this activity or this form, please contact Mr. Michael Giampetruzzi '95, Dean of Students at mgiampetruzzi@holycrosshs-ct.com or at 203.757.9248.
***The reverse side of this form contains a medical history that will be made available to those in charge during this field trip. Please complete this form as thoroughly as possible.*

MEDICAL HISTORY

Student's Name: _____ Birthdate: _____

Student lives with: _____ Home Phone: _____

Student's Primary Physician: _____ Office Phone: _____

Does your child see any specialists? YES NO
If yes, please list: _____

Does your child have any food allergies? YES NO
If yes, please list: _____

Does your child have any allergies to medications? YES NO
If yes, please list: _____

Does your child take any daily medications? YES NO
If yes, please describe:

Medication: _____ Dose: _____ Time Given: _____

Medication: _____ Dose: _____ Time Given: _____

Medication: _____ Dose: _____ Time Given: _____

Medication: _____ Dose: _____ Time Given: _____

Does your child take any medication on an as-needed basis? YES NO
If yes, please list: _____

Does your child have seizures? YES NO
If yes, what type of seizures does your child experience? _____
Date of your child's last seizures: _____

Does your child have any cardiac problems? YES NO
If yes, please list: _____

Does your child have any history of asthma? YES NO
When was the last time your child had an asthma attack? _____
What was done to treat your child's asthma? _____

Are there any other medical concerns that you would want the nurse to know?
If so, please list: _____

If you have any questions or concerns,
please do not hesitate to contact the school nurse at 203.757.4171.