

NEW BRAUNFELS CHRISTIAN ACADEMY

Field Trip Form

Student's Name:		Date of Birth:	Sex:	Grade:
Social Security #		Address:		Zip:
Father/Guardian		Employed At:	Work #	
Mother/Guardian		Employed At:	Work #	
Home Phone #		Cell Phone #:		
<p>Emergency Number: If parent(s) are not available, please indicate alternate adult(s) whom the school should call. Please indicate relationship, i.e. neighbor, aunt, etc... List those who can pick up your child during school hours. Students will NOT be released to persons not listed on this document.</p>				
NAME:		RELATIONSHIP:	PHONE #	
NAME:		RELATIONSHIP:	PHONE #	
NAME:		RELATIONSHIP:	PHONE #	
Family Doctor & Phone #		Family Dentist & Phone #		
<p>1. I GIVE APPROPRIATE HEALTH OR ADMINISTRATIVE PERSONNEL AUTHORITY TO CALL THE DOCTOR CONCERNING MEDICAL NEEDS: YES _____ NO _____</p> <p>2. MY CHILD HAS HAD THE FOLLOWING ILLNESSES: CIRCLE ALL THAT APPLY: Allergy (Specify to what) _____ Asthma _____ Epilepsy (Seizures) _____ Chicken Pox: Month _____ Year _____</p> <p>3. CURRENT MEDICATION: _____</p> <p>4. OTHER HEALTH CONDITIONS YOUR CHILD MIGHT HAVE: _____</p> <p>5. MY CHILD WEARS GLASSES: (Circle One) YES NO MY CHILD WEARS CONTACTS: YES NO</p> <p>6. MY CHILD IS COVERED BY THE FOLLOWING MEDICAL INSURANCE PLAN: _____</p> <p>7. IMMUNIZATIONS: DATE OF LAST TETANUS: _____</p>				

NBCA does not assume any financial responsibility but does wish to provide emergency care. By signing this card, you are giving the appropriate school personnel authority to call EMS, to transport, or obtain medical care if you or the alternate adults cannot be reached. I hereby grant permission for emergency medical care to be given by the attending physician and/or school personnel. I also give permission for EMS to be called and/or for my child to be transported as necessary by school personnel. I will NOT hold the school financially responsible for the emergency care and/or transportation of my child.

By signing below, I release the NBCA and employees from liability due to any adverse reaction or complications my child could have from taking medication I requested be given.

Signature of Parent/Guardian: _____ Date: _____

8. PARENT/GUARDIAN SIGNATURES VERIFIES ALL PROCEEDING INFORMATION AND CHANGES.