



Cypress-Fairbanks Independent School District

Parent Permission Form Fine Arts Field Trip

_____	_____	_____
Student Name (Last)	(First)	(Middle)
_____	_____	() - _____
Campus	Organization	Student Cell Phone (Optional)
_____	() - _____	() - _____
Parent/Guardian Name	Primary phone number	Secondary phone number
_____	() - _____	() - _____
Secondary Contact Name	Primary phone number	Secondary phone number

ACTIVITY: Cy-Fair High School Orchestra Events with/without district transportation. This includes UIL events, Community Outreach Performances, Annual Spring Trips, and any other school-sanctioned event.

PARENT ACKNOWLEDGMENT: In order for your student to participate in this school-sponsored activity, written parent permission is required below. Student safety is a high priority; however, under state law the school district is not responsible for medical or other costs associated with a student injury, unless the injury results from a school employee's negligent operation of a District vehicle. By completing and returning this form, you are authorizing your student to participate in the school-sponsored activity described above, and acknowledge that you are responsible for any medical or other costs associated with a student injury that may occur during the activity, except as stated above. Students are required to use District-provided transportation if it is provided as indicated above (unless the campus principal or designee has specifically authorized a student to arrive or depart separately and the parent/guardian has completed any additionally-required written permissions). The District shall not be liable or responsible for any action, injuries or damages that occur to students riding in vehicles that are not provided by the District.

If the above student needs immediate care and treatment as a result of injury or illness, I authorize CFISD employees to deliver or consent to care.

PRESCRIPTION MEDICATION ADMINISTRATION: Prescription medications administered by the school nurse during a regular school day will be transported/administered by the field trip sponsor for an activity limited to regular school hours.

_____	____/____/20____	() - _____
Parent/Legal Guardian Signature	Date	Insurance phone number

_____	_____
Name of Insurance Company	Identification or Group Number

Please provide a copy of the student's current insurance card.

In case of a student emergency, CFISD employees should be knowledgeable your child's medical conditions to provide safe care. Please list any medical conditions or regular medications below.

- Asthma Diabetes Seizure Disorder List Severe Food Allergies _____
- Daily and Emergency Medications: _____
- Other Information: _____

_____ / _____ / _____
Student Name (Last) (First) (Middle)

Complete this section ONLY if your child requires the administration of a non-prescription or prescription medication during an activity **extending beyond the regular school day**, please list the medication(s) you authorize CFISD staff members to administer in the table below. The field trip sponsor will provide instructions for parents/guardians to drop-off required medication(s) before the event. In accordance with CFISD Board policy FFAC (LOCAL), medication must be supplied in the original container (labeled for the student), and students may not transport medications to or from school or a school-sponsored event.

Medication Name	Dose	Route	Time

_____/_____/20
Parent/Legal Guardian Signature Date

District Provided Non-prescription Medication Permission

Authorization is hereby given for the administration of the following district provided non-prescription medications to my child by designated school employees. Circle Yes or No in last column.

Symptom	Medication	Brand Name	Circle Yes or No
Allergic Reaction	Diphenhydramine	Benadryl	Yes or No
Mild Pain/Fever	Ibuprofen	Addaprin, Motrin	Yes or No
Mild Pain/Fever	Acetaminophen	Tylenol	Yes or No
Mild Abdominal Pain Heartburn, Nausea	Calcium Carbonate Chews	Tums, Maalox	Yes or No

_____/_____/20
Parent/Legal Guardian Signature Date

Medication Log (For CFISD Use Only)

Date: (Month/Day)	Time	Signs & Symptoms	Medication Dispensed	Initials
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/				
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