



PERMISSION TO TRAVEL FORM

Parents/Guardians: Please complete this form and return it to the Director in order for your student to tour with the group!

- ➔ GTP provides Group Liability Insurance Coverage but does not provide Personal Insurance. We recommend that you purchase Individual Insurance with iTravelInsured through our website. Logon to www.grouptravelplanners.com, click on the Services Tab, under Services, click on iTravelInsured.

I give _____ (Name of Student) permission to travel with _____
_____ (Name of High School) to _____ (Tour Destination).

I _____ (Name of the person in consent) assume all risks that may be involved in the participation of this tour and I do release, indemnify, and agree to hold harmless the above School mentioned - as well as Group Travel Planners, its agents, employees, chaperones, leaders, organizers, sponsors, and persons transporting the Student to and from their trip/activities. Neither the above mentioned School, Group Travel Planners, nor any of the said persons will be held financially responsible for any stolen property, injury, illness, or death incurred as a direct/indirect result of this activity.

I understand that if the Student becomes involved in anything that may result in punitive action, the Directors can decide to send the Student home at your expense. The Director will contact you before such an action occurs.

Group Travel Planners acts only as an agent for tour members in arranging accommodations, transportation, and other such details (meals, sightseeing, etc.) pertinent to the tour. Group Travel Planners may change the itinerary if necessary and is not responsible to any person/institution for any losses beyond their control (transportation problems/airline delays).

I, the undersigned, have read and understand all of the terms of this release and execute it voluntarily fully understanding the importance of the details of this form.

Signature of Parent/Guardian: _____ Date: _____

Cell Phone: _____ Other: _____

740 Southcross Drive West, Suite 205, Burnsville, MN. 55306
Tel: 952-898-3478 • Toll Free: 1-800-268-0243 • Fax: 952-898-2467
www.grouptravelplanners.com



MEDICAL CONSENT PERMIT FORM

NOTE: Most medical facilities require that this form be notarized prior to treating the Student.

Student's Name	Contact Person (In case of emergency)
Parent/Guardian's Name	Emergency Phone Number
Home Address	Family Physician
City, State, & Zip Code	Family Physician's Phone Number
Home Phone Number	Health Insurance Company Name
Parent/Guardian's Work Phone	Health Insurance Policy Number

Medications Currently Prescribed:	
Dosage/Frequency:	Date of Birth:
Allergies/Allergic Reactions to Medications:	
Major Surgeries:	Date of last Tetanus Shot:
Acute/Chronic Medical Conditions:	
Physical Conditions that may limit activity:	
Special Dietary Needs:	

PARENTAL CONSENT FORM/RESPONSIBILITY CLAUSE/MEDICAL PERMIT

I give _____ (Name of Student) permission to participate in the _____ (Destination) Tour. I understand that _____ (Name of High School) and every person involved in this tour is not to be held liable for any death, injury, damage, delay, or irregularity that may occur on this tour. If my child needs to take medications while on this tour, I give permission for him/her to do so. I understand that medications must be carried in the original (labeled) container and that prescription medications must be listed on this form. If there is an emergency, I give consent for a qualified physician to perform the necessary procedures. I understand that the staff will make every effort to contact me before any action is taken. I authorize the physician to hospitalize and use other medications as he/she deems medically needed. If a licensed physician is traveling on the tour, I authorize him/her to administer medications that may arise while on tour.

Parent/Guardian's Signature	Date	Relationship to Student
Student's Signature	Date	Notary Signature - Date

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**Ankeny Community Schools
Request for Giving Medication at School**

Student's Name: _____ **Grade:** _____ **Teacher:** _____

School medications and health care services are administered following these guidelines:

- Parent signed and dated authorization to administer the medication.
- The medication must be in the prescription container or the container in which it was purchased.
- The medication label contains the student name, name of the medication, directions for use and date.
- Annual renewal of authorization and immediate notification, in writing, of changes.

Name of Medication: _____

Dosage: _____

Dates to be Given: _____

Time to be Given: _____

Doctor Who Prescribed Medication: _____

Additional Information or Administration Instructions: _____

I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the doctor/prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment .

Parent/Guardian Signature: _____ **Date:** _____

-Students MUST bring their own supply of medication to school. The medication will be kept in the nurse's office and it MUST be in the original container.

-For more information refer to board policy #504.32 at www.ankenyschools.org

Reviewed 3/09