

## 2019-2020 ECS Activity Traveling Form

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Insurance No. \_\_\_\_\_

### Activity Traveling Permission

I (We), the parent(s)/guardian(s) of \_\_\_\_\_, a student at Elyria Christian School, give permission for my/our child to participate in all ECS trips for activities. Travel may include ECS vehicles and/or designated staff or parent vehicles. I/We understand that reasonable precautions will be taken to safeguard my/our child during the trips, and I/we will not hold ECS or designated staff or parent drivers responsible for any accidents or losses which might be sustained during the trip.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

### Release for Emergency Medical Treatment

I (We), the parent(s)/guardian(s) of \_\_\_\_\_, a student at Elyria Christian School, hereby authorize the school staff, including coaches and activity sponsors, to perform or procure whatever emergency medical treatment is deemed necessary for the assistance of my/our child. This may include transportation to a local hospital or summoning emergency medical help to the site of the activity. Although every effort will be made to contact me/us as soon as possible, I agree the above emergency measures may be performed prior to me/our knowledge and that I/we assume full responsibility for any financial liability thereof.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

### Nonprescription Medical Release

(circle any medications your child may take at activities)

Tylenol

Advil

Allergy Relief

Tums

Cough drops

I (We) the parent(s)/guardian(s) of \_\_\_\_\_, give my/our permission for ECS school staff to administer the above nonprescription medications as noted above or as directed on the bottle to my/our child. I/We understand that any school employee who administers any of the above listed drugs to my/our child in accordance with the written instructions above or on the bottle shall not be liable for damages as a result of an adverse drug reaction suffered by my/our child because of administering such drug.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

Student's Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian Cell Phone(s) \_\_\_\_\_

Emergency Contact (in case parents/guardians cannot be reached)

\_\_\_\_\_  
Phone \_\_\_\_\_