Trip

Dear parents,

We will be visiting the Biosphere 2 in Oracle, Arizona January 20-22. The cost is $125, and the due date for the last payment is January 15th. Money should go to Lisa and can be cash or check made out to Innovations Academy.

Please indicate: My child WILL / WILL NOT be attending this trip.

Please fill out below...

EMERGENCY CONTACT FORM AND HEALTH INFORMATION

Student Name: _____ M F Birthday_____

EMERGENCY CONTACTS (other than parents)

Emergency Contact #1:_____ Phone: _____Home___ Cell___ Work__

Emergency Contact #2:_____ Phone: _____Home___ Cell___ Work__

INSURANCE INFORMATION

Student's Doctor: _____Doctor's Phone:_____

Insurance Carrier: _____

Name of Insured: _____ Policy #: _____

Student's Allergies/Health Concerns: (□ check here if no allergies or health concerns) •Allergies_____
•AsthmaMedication: _____

•Anaphylaxislife threatening allergic reaction to: _____

•Diabetes •Migraine Headaches •Seizure Disorder

•Other_____

Is your child on any daily medication? Yes/No _____ _____

I authorize the Innovations Academy representative to administer the following over the counter medications on an "as needed" basis during the field trip...

□ Acetaminophen (generic Tylenol) □ Ibuprofen (generic Advil or Motrin) □ Chewable Antacid (generic TUMS) □ Menstrual (generic Midol or Pamprin) □ Antihistamine (generic Benadryl) □ Cough Drops

□ I do not want my student receiving any of these medications.

Authorization to Consent to Treatment of My Child while on the Biosphere 2 Trip

I hereby authorize the Innovations Academy representative to consent to any Xray examination, anesthetic, medical, or surgical diagnosis or treatment or hospital care that is deemed advisable by, and is to be rendered under the supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act or to consent to any Xray examination, anesthetic, medical, or surgical diagnosis or treatment or hospital care that is deemed advisable by, and is to be rendered under the supervision of any dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, hospital, or otherwise.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of said agent(s) to give specific consent to any and all such diagnosis, treatment and hospital care that such physician or dentist in the exercise of his/her best judgment may deem.

This authorization is given pursuant to the provisions of Family Code Section 65506552 of California and shall remain effective until revoked. It is understood that every effort will be made by Innovations Academy to contact me before exercising this authorization.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____