**Conduct Requirements**

This information was agreed to before you were allowed to register your child for the trip. It was included in the trip flier. This copy is for our records. Students who receive disciplinary consequences as a result of violating FCS Code of Conduct may not be allowed to attend the trip and costs associated with the trip may be forfeited. Please note that final decisions about trip eligibility will be made by Northwestern administration.

__________________________________
Parent Signature                     Date

__________________________________
Student Signature                   Date

**Movie Permission**

Student’s Name ________________________ Homeroom: ________________________

_____ Yes, my child has permission to view G, PG and PG-13 videos.

_____ No, my child does not have permission to view the videos.

__________________________________
Parent Signature                     Date
Medical Authorization

State of Georgia
County of Fulton

My child, ____________________________________________, has permission to attend the Northwestern Middle School trip to Washington, D.C., May 6-9, 2020. In the event of illness or accident, I hereby give my consent for the necessary emergency medical treatment of said child. Please attempt to notify me concerning any such emergency.

____________________________________________
Parent/Guardian Signature                      Date

Information for Medical Treatment:

Child: ____________________________  Birthdate: ____________________________

Address: ____________________________

__________________________  Zip Code: ____________________________

Father’s Full Name ____________________________________________________________

Mother’s Full Name ____________________________________________________________

Home Phone: __________  Cell Phone: __________  Other Phone: __________

Place of Employment __________________________________________________________

Insurance Company: __________________________________________________________

Must have hospitalization insurance or a signed waiver in order to go on the trip.

Policy Number: _____________________________________________________________

Allergic to any medications? Identify: __________________________________________

Taking any medications? Identify: _____________________________________________

Date of last tetanus shot (THIS INFORMATION IS REQUIRED): _____________________

Physician’s Name: ____________________________  Physician’s phone #: ________________

List of medications to be carried on the trip, including aspirin: _______________________

________________________________________________________________________________________