☐ CHECK IF OVERNIGHT

OLYMPIA SCHOOL DISTRICT
ATHLETICS & ACTIVITIES OFF-CAMPUS TRIP REQUEST

SCHOOL	SPORT/ACTIVITY	REQUESTED BY	
DESTINATION			
DEPARTURE DAY/DATE	TIME	RETURN DAY/DATE	TIME
PURPOSE OF TRIP (OBJECTIVES)			
ITINERARY OVERVIEW (ATTACH DETAILS)			
TYPE OF EVENT (PARADE, CONTEST, RETREAT, MEET, TEAM CAMP, ETC.)			
PERSON(S) IN CHARGE		GROUP (DEBATE, BAND, ETC.)	

# STUDENTS M: F:	ADULTS ACCOMPANYING (LIST NAMES-ATTACH ADDITIONAL PAGE IF NEEDED) REQUIRED: ONE PER 10 STUDENTS DAY TRIP / ONE PER 6 STUDENTS OVERNIGHT	CELL PHONE CONTACT
# TEACHER CHAPERONES M: F:		PHONE @ DESTINATION
# PARENT CHAPERONES M: F:		ADD'L CONTACT PHONE

COST OF TRIP

TRANSPORTATION	SCHOOL BUS	CHARTER BUS	FERRY	PRIVATE VEHICLE	OTHER	$
HOUSING	MOTEL	HOTEL	DORM	PRIVATE HOME	OTHER	$
FOOD	INDIVIDUAL MEALS		GROUP MEALS		OTHER	$
OTHER COSTS	SPECIFY:					$
					TOTAL COST OF TRIP	$

SOURCE OF FUNDS

BUILDING BUDGET ACCOUNT #	$	INDIVIDUAL STUDENT	$
STUDENT BODY ACCOUNT #	$	OTHER (SPECIFY)	$
		TOTAL SOURCE OF FUNDS	$

PRE-TRIP REQUIREMENTS

☐	I WILL ACQUIRE A PERMISSION SLIP FOR EACH STUDENT: LEAVE ONE COPY W/OFFICE; RETAIN ORIGINAL FOR TRIP.
☐	I HAVE HAD MY CURRENT PARTICIPANT LIST REVIEWED FOR HEALTH CONCERNS AND HAVE ANY NEEDED EMERGENCY ACTION PLANS.
☐	I HAVE BEEN TRAINED BY THE SCHOOL NURSE TO ADMINISTER MEDICATIONS.
☐	I HAVE A FIRST AID KIT FOR EVERY VEHICLE.
☐	SCHOOL NURSE IS AWARE OF TRIP AND HAS REVIEWED STUDENT LIST FOR HEALTH CONCERNS & MEDICATIONS PRIOR TO DEPARTURE.

APPROVALS (REQUIRED— 2 WEEKS IN ADVANCE OF TRIP FOR DAY TRIP / 4 WEEKS IN ADVANCE FOR OVERNIGHT)

PRINCIPAL	DATE	ATHLETIC DIRECTOR	DATE

ASSISTANT SUPERINTENDENT & SUPERINTENDENT APPROVALS REQUIRED FOR OVERNIGHTS AND/OR HIGH RISK TRIPS OR ACTIVITIES

DIRECTOR, HEALTH, FITNESS & ATHLETICS	DATE	SUPERINTENDENT	DATE

DATE OF BOARD APPROVAL (REQUIRED FOR OVERNIGHT)