

**TOMBALL INDEPENDENT SCHOOL DISTRICT
CO-CURRICULAR/EXTRACURRICULAR TRIPS**

Date 8/19/25

Dear Parent/Guardian:

Your child has the opportunity to participate in an event that will take him/her off campus. To be able to do this, you must complete the form below and return it to Mr. Vierkant no later than 10/7/25. It must be completed and signed before your student will be allowed to travel.

Student Name (PRINT) _____ Grade _____

Date of Birth: _____ Male/Female (circle one) Campus THS Home Phone _____

Father/Stepfather: _____ Work # _____ Second Number _____

Mother/Stepmother: _____ Work # _____ Second Number _____

Alternate Emergency Contact: _____ Phone # _____ Relation _____

Medication/s taken routinely at home: _____

Medication

Medical Information about student:

Insurance Provider _____ Policy Number _____

Existing medical condition/s: _____

Allergies: _____

/s taken routinely at school: _____

I DO / DO NOT want my child's teacher to administer the school medication(s) as directed during the field trip.
(circle one)

Special considerations: _____

My child, (Print name) _____, has my permission to participate in the following activity: **Senior Picnic**

Cost per Student Free Transportation by TISD buses

Date Leaving: 10/8/25 Time Leaving: 8:30 From (Location) THS

Date Returning: 10/8/25 Time Returning: 2:00 To (Location) THS

Additional Instructions from sponsor:

If you are interested in volunteering to help at Senior Picnic, please join the Senior Parents Organization and inquire to the board.

Name of Sponsor Mark Vierkant Assoc Prin

I, the undersigned, do hereby authorize officials of the Tomball I.S.D. to contact persons named on this sheet in the event of illness, injury and/or inappropriate behavior of my child. T.I.S.D. school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health and safety of said child. I realize that this form does not abrogate or modify my rights as a parent/guardian of a minor. I have voluntarily signed this form to facilitate and expedite the treatment of my child. I understand that costs of services provided by ambulance, private physician, clinic, hospital, or dentist remains my responsibility and will not be assumed by the district or any of its officers or employees.

DATE

Signature of Parent/Guardian