JACKSON SCHOOL DISTRICT
JACKSON CHILD CARE ACADEMY
SUMMER 2025 CAMP
PERMISSION FOR TRIPS

My child(ren)

1.______________________________________2.__________________________________

3.______________________________________4.__________________________________

has(have) permission to participate in the following:

PROGRAM @ SWITLIK: JACKSON CHILD CARE ACADEMY – 2025 JACKSON CHILD CARE ACADEMY SUMMER CAMP 8:00am - 5:00pm

FIELD TRIPS as scheduled by Jackson Child Care Academy – Summer Camp 2025 Staff (See activities list on the Child Care website https://www.jacksonchildcareacademy.com for trip locations)

Please note: All trips are subject to change due to weather and/or any unforeseen circumstances.

This is to certify that my child(ren) named above has(have) permission to participate in the specified trip(s) and to travel off school grounds with the group for the purpose of participating in the group's activities and events. I understand that, if circumstances warrant, including in case of disciplinary infractions, I may be contacted and requested to transport my child home prior to the end of the trip(s). I understand, further, that a separate consent form (waiver, release, hold harmless) requiring signature may be provided by a scheduled facility. These forms may be distributed and collected on-site by the appropriate Child Care Academy Lead Teacher.

I knowingly and voluntarily agree to waive any and all claims for liability, loss, injury, damages, or expenses which my child(ren) and I may have against the Jackson Township Board of Education, collectively and individually, and its agents, employees and chaperones resulting in any way from participation in the listed activities and related transportation.

I have read and understood the above policy and give permission for my child(ren) to participate in the above-referenced program. I authorize the release of the information contained in this form to the responsible program advisor/trip chaperone. In the event of a medical emergency, I authorize the Jackson School District and its faculty member in charge of my child(ren), to obtain all necessary medical care and further authorize any licensed physician and/or medical personnel to render all necessary medical treatment.

Parent / Guardian Acknowledgement/Agreement Signature:

____

Print Name

____ Date: ______________

Sign Name