

STUDENTS

09.36 AP.21

**School-Related Student Trip Request Form & Event Specific Emergency Action Plan (EAP)**

SCHOOL: TCMS

FACULTY MEMBER(S) SPONSORING TRIP : HEATHER KEY

TYPE OF TRIP (CHECK ONE): CBI COMMUNITY BASED INSTRUCTION

Organization requesting the Trip / Organization responsible for Payment: SPED TCBOE

DESTINATION: LOGAN ALUMINUM ADDRESS: 6920 LEWISBURG RD. RUSSELLVILLE, KY

☐ Overnight; give name, address, phone of lodging \_\_\_\_\_

DATE(S) OF TRIP: TUESDAY, DECEMBER 16, 2025 DEPARTURE TIME: 9:30

RETURN TIME: 12:00

SOURCE OF FUNDING FOR TRIP: SPED TCBOE

*NO STUDENT SHALL BE DENIED THE TRIP BECAUSE OF AN INABILITY TO PAY.*

NUMBER OF: STUDENTS 10 FACULTY SPONSORS 5 TOTAL # OF PARTICIPANTS 15

EAP: Person contacted at venue to discuss EAP: Lisa Ann Turner

Person making contact: Heather Key

Is there an Automated External Defibrillator (AED) on site: ☒ Yes ☐ No If yes, where: \_\_\_\_\_

Does the venue have an Emergency Response Team: ☒ Yes ☐ No If yes, how are they contacted: Radio, onsite at all times

School Employee(s) Attending Trip (Please note beside name if employee is CPR trained):

Heather Key, Kim McCormick, Belinda Garrett, Nancy Tucker, Jennifer Mumford

(Please use separate sheet and attach to this form if more space is needed to list school employees attending).

Signature of Faculty Sponsor

Date

Approval of Site Based Council Representative

Date

**District Use Only**

**Section 2**

Approval of District Representative

Date

**DRIVER: TURN THIS FORM IN WITH TIMESHEETS**

**Section 3**

Date/Time Departure:

Odometer

Start:

Date/Time Return:

Odometer End:

I hereby certify that the above information is correct to the best of my knowledge.

Driver Signature

Date

Driver Comments:

Coach or School Representative Signature

Date

STUDENTS

09.36 AP.21

**School-Related Student Trip Request Form & Event Specific Emergency Action Plan (EAP)**

SCHOOL: TCMS

FACULTY MEMBER(S) SPONSORING TRIP : HEATHER KEY

TYPE OF TRIP (CHECK ONE): CBI COMMUNITY BASED INSTRUCTION

Organization requesting the Trip / Organization responsible for Payment: SPED TCBOE

DESTINATION: DOLLAR TREE & McDONALD'S

ADDRESS: RUSSELLVILLE, KY

☐ Overnight; give name, address, phone of lodging \_\_\_\_\_

DATE(S) OF TRIP: THURSDAY, DECEMBER 11, 2025

DEPARTURE TIME: 10:15

RETURN TIME: 2:00

SOURCE OF FUNDING FOR TRIP: SPED TCBOE

*NO STUDENT SHALL BE DENIED THE TRIP BECAUSE OF AN INABILITY TO PAY.*

NUMBER OF: STUDENTS 10 FACULTY SPONSORS 5 TOTAL # OF PARTICIPANTS 15

EAP: Person contacted at venue to discuss EAP: Store Manager Person making contact: Heather Key

Is there an Automated External Defibrillator (AED) on site: ☐ Yes ☒ No If yes, where: \_\_\_\_\_

Does the venue have an Emergency Response Team: ☐ Yes ☒ No If yes, how are they contacted: Call 911

School Employee(s) Attending Trip (Please note beside name if employee is CPR trained):

Heather Key, Kim McCormick, Belinda Garrett, Nancy Tucker, Jennifer Mumford

(Please use separate sheet and attach to this form if more space is needed to list school employees attending).

Signature of Faculty Sponsor

Date

Approval of Site Based Council Representative

Date

11/24/25

**District Use Only**

**Section 2**

Approval of District Representative \_\_\_\_\_

Date \_\_\_\_\_

**DRIVER: TURN THIS FORM IN WITH TIMESHEETS**

**Section 3**

Date/Time Departure: \_\_\_\_\_

Odometer

Start: \_\_\_\_\_

Date/Time Return: \_\_\_\_\_

Odometer End: \_\_\_\_\_

I hereby certify that the above information is correct to the best of my knowledge.

Driver Signature \_\_\_\_\_

Date \_\_\_\_\_

Driver Comments: \_\_\_\_\_

Coach or School Representative Signature \_\_\_\_\_

Date \_\_\_\_\_

STUDENTS

09.36 AP.21

**SchoolRelated Student Trip Request Form & Event Specific Emergency Action Plan (EAP)**

SCHOOL TCMS FACULTY MEMBER(S) SPONSORING TRIP LISA PETRIE- EVAN CANTARELLI

**TYPE OF TRIP (CHECK ONE):**

Organization requesting the Trip / Organization responsible for Payment: TCMS ACADEMIC TEAM

DESTINATION TBD

☐ Overnight; give name, address, phone of lodging \_\_\_\_\_

DATE(S) OF TRIP SAT. FEB 14, 2026 DEPARTURE TIME 7:00 AM RETURN TIME @3:30 PM

SOURCE OF FUNDING FOR TRIP TCMS ACADEMIC TEAM

*NO STUDENT SHALL BE DENIED THE TRIP BECAUSE OF AN INABILITY TO PAY.*

NUMBER OF: STUDENTS 20 FACULTY SPONSORS 3 TOTAL # OF PARTICIPANTS 28

EAP: Person contacted at venue to discuss EAP: \_\_\_\_\_ Person making contact: Lisa Petrie

Is there an Automated External Defibrillator (AED) on site: ☒ Yes ☐ No If yes, where: \_\_\_\_\_

Does the venue have an Emergency Response Team: ☐ Yes ☐ No If yes, how are they contacted: \_\_\_\_\_

School Employee(s) Attending Trip (Please note beside name if employee is CPR trained):

Evan Cantarelli

Lisa Petrie

Elizabeth Addison

(Please use separate sheet and attach to this form if more space is needed to list school employees attending).

Lisa Petrie

11/23/25

*Signature of Faculty Sponsor*

*Date*

Approval of Site Based Council Representative [Signature]

Date 11/24/25

**District Use Only**

**Section 2**

Approval of District Representative \_\_\_\_\_ Date \_\_\_\_\_

**DRIVER: TURN THIS FORM IN WITH TIMESHEETS**

**Section 3**

Date/Time Departure: \_\_\_\_\_ O d o m e t e r \_\_\_\_\_ S t a r t : \_\_\_\_\_

Date/Time Return: \_\_\_\_\_ Odometer End: \_\_\_\_\_

I hereby certify that the above information is correct to the best of my knowledge.

Driver Signature \_\_\_\_\_ Date \_\_\_\_\_

Driver Comments: \_\_\_\_\_

Coach or School Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

STUDENTS

09.36 AP.21

**SchoolRelated Student Trip Request Form & Event Specific Emergency Action Plan (EAP)**

SCHOOL TCMS FACULTY MEMBER(S) SPONSORING TRIP LISA PETRIE- EVAN CANTARELLI

TYPE OF TRIP (CHECK ONE):

Organization requesting the Trip / Organization responsible for Payment: TCMS ACADEMIC TEAM

DESTINATION TBD

☐ Overnight; give name, address, phone of lodging \_\_\_\_\_

DATE(S) OF TRIP WED. FEB 4, 2026 DEPARTURE TIME TBD RETURN TIME TBD

SOURCE OF FUNDING FOR TRIP TCMS ACADEMIC TEAM

*NO STUDENT SHALL BE DENIED THE TRIP BECAUSE OF AN INABILITY TO PAY.*

NUMBER OF: STUDENTS 6 FACULTY SPONSORS 1 TOTAL # OF PARTICIPANTS 7 VAN REQUEST

EAP: Person contacted at venue to discuss EAP: \_\_\_\_\_ Person making contact: Lisa Petrie

Is there an Automated External Defibrillator (AED) on site: ☒ Yes ☐ No If yes, where: \_\_\_\_\_

Does the venue have an Emergency Response Team: ☐ Yes ☐ No If yes, how are they contacted: \_\_\_\_\_

School Employee(s) Attending Trip (Please note beside name if employee is CPR trained):

Lisa Petrie

(Please use separate sheet and attach to this form if more space is needed to list school employees attending).

Lisa Petrie

*Signature of Faculty Sponsor*

11/23/25

*Date*

Approval of Site Based Council Representative [Signature]

Date 11/24/25

**District Use Only**

**Section 2**

Approval of District Representative \_\_\_\_\_ Date \_\_\_\_\_

**DRIVER: TURN THIS FORM IN WITH TIMESHEETS**

**Section 3**

Date/Time Departure: \_\_\_\_\_ O d o m e t e r \_\_\_\_\_ S t a r t : \_\_\_\_\_

Date/Time Return: \_\_\_\_\_ Odometer End: \_\_\_\_\_

I hereby certify that the above information is correct to the best of my knowledge.

Driver Signature \_\_\_\_\_ Date \_\_\_\_\_

Driver Comments: \_\_\_\_\_

Coach or School Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

STUDENTS

09.36 AP.21

**SchoolRelated Student Trip Request Form & Event Specific Emergency Action Plan (EAP)**

SCHOOL TCMS FACULTY MEMBER(S) SPONSORING TRIP LISA PETRIE- EVAN CANTARELLI

TYPE OF TRIP (CHECK ONE):

Organization requesting the Trip / Organization responsible for Payment: TCMS ACADEMIC TEAM

DESTINATION TBD

☐ Overnight; give name, address, phone of lodging \_\_\_\_\_

DATE(S) OF TRIP TUES. JAN. 13, 2026 DEPARTURE TIME TBD RETURN TIME TBD

SOURCE OF FUNDING FOR TRIP TCMS ACADEMIC TEAM

*NO STUDENT SHALL BE DENIED THE TRIP BECAUSE OF AN INABILITY TO PAY.*

NUMBER OF: STUDENTS 6 FACULTY SPONSORS 1 TOTAL # OF PARTICIPANTS 7 VAN REQUEST

EAP: Person contacted at venue to discuss EAP: \_\_\_\_\_ Person making contact: Lisa Petrie

Is there an Automated External Defibrillator (AED) on site: ☒ Yes ☐ No If yes, where: \_\_\_\_\_

Does the venue have an Emergency Response Team: ☐ Yes ☐ No If yes, how are they contacted: \_\_\_\_\_

School Employee(s) Attending Trip (Please note beside name if employee is CPR trained):

Lisa Petrie

(Please use separate sheet and attach to this form if more space is needed to list school employees attending).

Lisa Petrie

11/23/25

*Signature of Faculty Sponsor*

*Date*

Approval of Site Based Council Representative [Signature]

Date 11/24/25

**District Use Only**

**Section 2**

Approval of District Representative \_\_\_\_\_ Date \_\_\_\_\_

**DRIVER: TURN THIS FORM IN WITH TIMESHEETS**

**Section 3**

Date/Time Departure: \_\_\_\_\_ O d o m e t e r \_\_\_\_\_ S t a r t : \_\_\_\_\_

Date/Time Return: \_\_\_\_\_ Odometer End: \_\_\_\_\_

I hereby certify that the above information is correct to the best of my knowledge.

Driver Signature \_\_\_\_\_ Date \_\_\_\_\_

Driver Comments: \_\_\_\_\_

Coach or School Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

STUDENTS

09.36 AP.21

**SchoolRelated Student Trip Request Form & Event Specific Emergency Action Plan (EAP)**

SCHOOL TCMS FACULTY MEMBER(S) SPONSORING TRIP LISA PETRIE- EVAN CANTARELLI

**TYPE OF TRIP (CHECK ONE):**

Organization requesting the Trip / Organization responsible for Payment: TCMS ACADEMIC TEAM

DESTINATION TBD

☐ Overnight; give name, address, phone of lodging \_\_\_\_\_

DATE(S) OF TRIP SAT. JAN. 17, 2026 DEPARTURE TIME 7:00 AM RETURN TIME @3:30 PM

SOURCE OF FUNDING FOR TRIP TCMS ACADEMIC TEAM

*NO STUDENT SHALL BE DENIED THE TRIP BECAUSE OF AN INABILITY TO PAY.*

NUMBER OF: STUDENTS 20 FACULTY SPONSORS 3 TOTAL # OF PARTICIPANTS 28

EAP: Person contacted at venue to discuss EAP: \_\_\_\_\_ Person making contact: Lisa Petrie

Is there an Automated External Defibrillator (AED) on site: ☒ Yes ☐ No If yes, where: \_\_\_\_\_

Does the venue have an Emergency Response Team: ☐ Yes ☐ No If yes, how are they contacted: \_\_\_\_\_

School Employee(s) Attending Trip (Please note beside name if employee is CPR trained):

Evan Cantarelli

Lisa Petrie

Elizabeth Addison

(Please use separate sheet and attach to this form if more space is needed to list school employees attending).

Lisa Petrie

11/23/25

*Signature of Faculty Sponsor*

*Date*

Approval of Site Based Council Representative [Signature]

Date 11/24/25

**District Use Only**

**Section 2**

Approval of District Representative \_\_\_\_\_ Date \_\_\_\_\_

**DRIVER: TURN THIS FORM IN WITH TIMESHEETS**

**Section 3**

Date/Time Departure: \_\_\_\_\_ O d o m e t e r \_\_\_\_\_ S t a r t : \_\_\_\_\_

Date/Time Return: \_\_\_\_\_ Odometer End: \_\_\_\_\_

I hereby certify that the above information is correct to the best of my knowledge.

Driver Signature \_\_\_\_\_ Date \_\_\_\_\_

Driver Comments: \_\_\_\_\_

Coach or School Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

STUDENTS

09.36 AP.21

**School-Related Student Trip Request Form & Event Specific Emergency Action Plan (EAP)**

SCHOOL TCHS FACULTY MEMBER(S) SPONSORING TRIP CW3 FAGAN

**TYPE OF TRIP (CHECK ONE):**

Organization requesting the Trip / Organization responsible for Payment: JROTC

DESTINATION TCHS ADDRESS 515 W. Main St., Elkton, Ky

☐ Overnight; give name, address, phone of lodging \_\_\_\_\_

DATE(S) OF TRIP 4 Feb 2026 DEPARTURE TIME 1:00 pm RETURN TIME 2:30 pm

SOURCE OF FUNDING FOR TRIP JROTC

*NO STUDENT SHALL BE DENIED THE TRIP BECAUSE OF AN INABILITY TO PAY.*

NUMBER OF: STUDENTS 20 FACULTY SPONSORS 1 TOTAL # OF PARTICIPANTS 21

EAP: Person contacted at venue to discuss EAP: \_\_\_\_\_ Person making contact: \_\_\_\_\_

Is there an Automated External Defibrillator (AED) on site: ☒ Yes ☐ No If yes, where: \_\_\_\_\_

Does the venue have an Emergency Response Team: ☒ Yes ☐ No If yes, how are they contacted: \_\_\_\_\_

School Employee(s) Attending Trip (Please note beside name if employee is CPR trained):

CW3 FAGAN - CPR Cert

(Please use separate sheet and attach to this form if more space is needed to list school employees attending).

Signature of Faculty Sponsor

Approval of Site Based Council Representative

Date

25 NOV 2025  
Date 11/25/25

**District Use Only**

**Section 2**

Approval of District Representative \_\_\_\_\_ Date \_\_\_\_\_

**DRIVER: TURN THIS FORM IN WITH TIMESHEETS**

**Section 3**

Date/Time Departure: \_\_\_\_\_ Odometer Start: \_\_\_\_\_

Date/Time Return: \_\_\_\_\_ Odometer End: \_\_\_\_\_

I hereby certify that the above information is correct to the best of my knowledge.

Driver Signature \_\_\_\_\_ Date \_\_\_\_\_

Driver Comments:

Coach or School Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

STUDENTS

09.36 AP.21

**School-Related Student Trip Request Form & Event Specific Emergency Action Plan (EAP)**

SCHOOL TCMS FACULTY MEMBER(S) SPONSORING TRIP CW3 FAGAN

TYPE OF TRIP (CHECK ONE):

Organization requesting the Trip / Organization responsible for Payment: JROTC

DESTINATION TCMS ADDRESS 806 S Main St, Elkton, Ky  
☐ Overnight; give name, address, phone of lodging 42226

DATE(S) OF TRIP 29 Jan 2026 DEPARTURE TIME 0830 RETURN TIME \_\_\_\_\_

SOURCE OF FUNDING FOR TRIP JROTC

*NO STUDENT SHALL BE DENIED THE TRIP BECAUSE OF AN INABILITY TO PAY.*

NUMBER OF: STUDENTS 20 FACULTY SPONSORS 1 TOTAL # OF PARTICIPANTS 21

EAP: Person contacted at venue to discuss EAP: \_\_\_\_\_ Person making contact: \_\_\_\_\_

Is there an Automated External Defibrillator (AED) on site: ☒ Yes ☐ No If yes, where: \_\_\_\_\_

Does the venue have an Emergency Response Team: ☒ Yes ☐ No If yes, how are they contacted: \_\_\_\_\_

School Employee(s) Attending Trip (Please note beside name if employee is CPR trained):

CW3 FAGAN - CPR Cert

(Please use separate sheet and attach to this form if more space is needed to list school employees attending).

Signature of Faculty Sponsor [Signature] Date 11/24/25  
Approval of Site Based Council Representative [Signature] Date 11/24/25

**District Use Only**

**Section 2**

Approval of District Representative \_\_\_\_\_ Date \_\_\_\_\_

**DRIVER: TURN THIS FORM IN WITH TIMESHEETS**

**Section 3**

Date/Time Departure: \_\_\_\_\_ Odometer Start: \_\_\_\_\_  
Date/Time Return: \_\_\_\_\_ Odometer End: \_\_\_\_\_

I hereby certify that the above information is correct to the best of my knowledge.

Driver Signature \_\_\_\_\_ Date \_\_\_\_\_  
Driver Comments: \_\_\_\_\_

Coach or School Representative Signature \_\_\_\_\_ Date \_\_\_\_\_



Request to Place an Item on the AgendaName: Kimberly Davis TCHSAddress: 515 W. Main StTelephone number: 270-265-2511

Name of school children attend, if applicable: \_\_\_\_\_

Group represented: TCHS JROTCCheck if request was submitted to: ☒ Superintendent ☒ Board Chairperson

Conferred with following administrators (names): \_\_\_\_\_

Description of Issue: Out of state trip to CampAtterbury, this will also be an overnightstay on Jan 13-14, 2026Out of state trips to Northwest High School on Feb 17, 2026Out of state trip to Kenwood High School on Feb 28, 2026Specific Action Requested: Approve the out of state tripsCheck if you are: ☐ Board Member ☒ District Employee ☐ Community Member

All requests for items to be placed on the agenda must be submitted to the Superintendent prior to the Board meeting as specified in Board Policy 01.45. Items submitted shall require prior approval of the Superintendent.

Review/Revised: 3/13/2006

09.36 AP.21

STUDENTS

**School-Related Student Trip Request Form & Event Specific Emergency Action Plan (EAP)**

SCHOOL TCCHS & TCMS FACULTY MEMBER(S) SPONSORING TRIP CW3 FAGAN

**TYPE OF TRIP (CHECK ONE):**

Organization requesting the Trip / Organization responsible for Payment: JROTC

DESTINATION LUCAS OIL STADIUM ADDRESS 500 S Capitol Ave Indianapolis

☒ Overnight; give name, address, phone of lodging Camp Atherbury, Edinburgh, IN  
46124 812-526-1128

DATE(S) OF TRIP JAN 13-14, 2024 DEPARTURE TIME 0800 RETURN TIME 2:30

SOURCE OF FUNDING FOR TRIP JROTC

**NO STUDENT SHALL BE DENIED THE TRIP BECAUSE OF AN INABILITY TO PAY.**

NUMBER OF: STUDENTS 45 FACULTY SPONSORS 2 TOTAL # OF PARTICIPANTS 47

EAP: Person contacted at venue to discuss EAP: T. Hany Nagy Person making contact: CW3 FAGAN

Is there an Automated External Defibrillator (AED) on site: ☒ Yes ☐ No If yes, where: \_\_\_\_\_

Does the venue have an Emergency Response Team: ☒ Yes ☐ No If yes, how are they contacted: \_\_\_\_\_

School Employee(s) Attending Trip (Please note beside name if employee is CPR trained):

CW3 FAGAN - CPR Certified

(Please use separate sheet and attach to this form if more space is needed to list school employees attending).

Signature of Faculty Sponsor

Date

Approval of Site Based Council Representative

Date 11/24/25

**District Use Only**

**Section 2**

Approval of District Representative

Date

**DRIVER: TURN THIS FORM IN WITH TIMESHEETS**

**Section 3**

Date/Time Departure:

Odometer Start:

Date/Time Return:

Odometer End:

I hereby certify that the above information is correct to the best of my knowledge.

Driver Signature

Date

Driver Comments:

Coach or School Representative Signature

Date

STUDENTS

09.36 AP.21

**School-Related Student Trip Request Form & Event Specific Emergency Action Plan (EAP)**

SCHOOL TCCHS & TCHS FACULTY MEMBER(S) SPONSORING TRIP CW3 FAGAN

**TYPE OF TRIP (CHECK ONE):**

Organization requesting the Trip / Organization responsible for Payment: JROTC

DESTINATION Kenwood High School ADDRESS 215 E Pine Mountain Rd

☐ Overnight; give name, address, phone of lodging Clarksville, TN

DATE(S) OF TRIP 28 Feb 2026 DEPARTURE TIME 0600 RETURN TIME 1:00pm

SOURCE OF FUNDING FOR TRIP \_\_\_\_\_

**NO STUDENT SHALL BE DENIED THE TRIP BECAUSE OF AN INABILITY TO PAY.**

NUMBER OF: STUDENTS 15 FACULTY SPONSORS 1 TOTAL # OF PARTICIPANTS 16

EAP: Person contacted at venue to discuss EAP: \_\_\_\_\_ Person making contact: \_\_\_\_\_

Is there an Automated External Defibrillator (AED) on site: ☐ Yes ☐ No If yes, where: \_\_\_\_\_

Does the venue have an Emergency Response Team: ☐ Yes ☐ No If yes, how are they contacted: \_\_\_\_\_

School Employee(s) Attending Trip (Please note beside name if employee is CPR trained):

CW3 FAGAN - CPR cert

(Please use separate sheet and attach to this form if more space is needed to list school employees attending).

[Signature]  
Signature of Faculty Sponsor

25 NOV 2025

Date

Approval of Site Based Council Representative [Signature]

Date 11/25/25

**District Use Only**

**Section 2**

Approval of District Representative \_\_\_\_\_ Date \_\_\_\_\_

**DRIVER: TURN THIS FORM IN WITH TIMESHEETS**

**Section 3**

Date/Time Departure: \_\_\_\_\_ Odometer Start: \_\_\_\_\_

Date/Time Return: \_\_\_\_\_ Odometer End: \_\_\_\_\_

I hereby certify that the above information is correct to the best of my knowledge.

Driver Signature \_\_\_\_\_ Date \_\_\_\_\_

Driver Comments: \_\_\_\_\_

Coach or School Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

STUDENTS

09.36 AP.21

**School-Related Student Trip Request Form & Event Specific Emergency Action Plan (EAP)**

SCHOOL TCMS & TCMS FACULTY MEMBER(S) SPONSORING TRIP CW3 FAGAN

**TYPE OF TRIP (CHECK ONE):**

Organization requesting the Trip / Organization responsible for Payment: JROTC

DESTINATION Northwest High School ADDRESS 800 Lafayette Rd, Clarksville, TN

☐ Overnight; give name, address, phone of lodging \_\_\_\_\_

DATE(S) OF TRIP 14 Feb 2026 DEPARTURE TIME 0600 RETURN TIME 2pm

SOURCE OF FUNDING FOR TRIP JROTC

*NO STUDENT SHALL BE DENIED THE TRIP BECAUSE OF AN INABILITY TO PAY.*

NUMBER OF: STUDENTS 15 FACULTY SPONSORS 1 TOTAL # OF PARTICIPANTS 16

EAP: Person contacted at venue to discuss EAP: CW4 Perez Person making contact: CW3 Fagan

Is there an Automated External Defibrillator (AED) on site: ☒ Yes ☐ No If yes, where: \_\_\_\_\_

Does the venue have an Emergency Response Team: ☒ Yes ☐ No If yes, how are they contacted: \_\_\_\_\_

School Employee(s) Attending Trip (Please note beside name if employee is CPR trained):

CW3 Fagan - CPR Cert

(Please use separate sheet and attach to this form if more space is needed to list school employees attending).

[Signature]  
Signature of Faculty Sponsor

25 Nov 2025

Date

Approval of Site Based Council Representative [Signature]

Date 11/25/25

**District Use Only**

**Section 2**

Approval of District Representative \_\_\_\_\_ Date \_\_\_\_\_

**DRIVER: TURN THIS FORM IN WITH TIMESHEETS**

**Section 3**

Date/Time Departure: \_\_\_\_\_ Odometer Start: \_\_\_\_\_

Date/Time Return: \_\_\_\_\_ Odometer End: \_\_\_\_\_

I hereby certify that the above information is correct to the best of my knowledge.

Driver Signature \_\_\_\_\_ Date \_\_\_\_\_

Driver Comments: \_\_\_\_\_

Coach or School Representative Signature \_\_\_\_\_ Date \_\_\_\_\_