

Trinity Lutheran School

REQUEST TO VISIT

THIS FORM MUST BE COMPLETED AND IN THE SCHOOL OFFICE 24 HOURS PRIOR TO THE VISIT.

Name of Classroom Visitor _____

Date of Visit _____

Time of Visit: 8:30-Noon Noon-3:10

Grade Being Visited: 5 6 7 8

Will the Visitor be present for lunch? Yes No

Name of Host _____

Name and Phone Number of Adult Responsible for Classroom Visitor:

(Please list phone number where adult may be reached during the time of the visit).

Classroom Visitor and Visitor's Parent/Legal Caregiver are to read and sign the following releases:

I understand that Classroom Visitors are expected to observe the same rules and procedures as students. I understand that failure to observe the rules and procedures of the school will result in immediate termination of the visit.

Signature of Parent/Legal Caregiver

Signature of Classroom Visitor

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact emergency services and/or transport my child to the emergency room of a hospital. The hospital is authorized to provide emergency treatment.

Please identify any allergies or other medical conditions:

Signature of Parent/Legal Caregiver

Date

This classroom visit has been approved by

Principal

Classroom Teacher

Classroom Teacher

Classroom Teacher