Madison County Schools
Out-of-County/Overnight Field Trip Medical Release Form

Student's Name: ______________________

Street Address: ______________________

City: ______________ Zip__________

Date of Birth: ______________________

If unable to reach parent/guardian, please notify:

Name: ______________________

Relationship: ______________________

Home ph #: ______________________

Cell ph # or Pager: ______________________

Parent/Guardian Contact: ______________________

Address: ______________________

Home Ph# ______________________

Work Ph# ______________________

Cell Ph # or Pager: ______________________

Medical Insurance Information:

Provider: ______________________

Contract# : ______________________

Group#: ______________________

Student's General Health Information:

1. Will your child need medication while on the field trip? YES NO
   (A completed and signed *School Medication Prescriber/Parent Authorization Form* is required for each medication (prescription or over-the-counter) to be administered during the field trip).
2. Does your child have allergies? YES NO If yes, please list: ______________________
   Does your child require medication to treat severe allergic reactions to insect stings/bites, food, etc.? ______
   (If yes, a copy of the completed and signed *Emergency Plan for Severe Allergy* form and the form(s) for related medication(s) must accompany this form).
3. Does your child have asthma? YES NO
   (If yes, a copy of the *student Asthma Action Plan* and related medication authorization forms must accompany this form).
4. Does your child have diabetes? YES NO
   (If yes, a copy of the *student Plan of Care* and related medication authorization forms must accompany this form).
5. Date of child's last Tetanus Booster shot: ______________________
6. Is there any other health history that may assist the person in charge if this student should become ill?
   ____
   ____

Student's Physician: ______________________
Address: ______________________ Phone # ______________
City: ______________ State: ______________ Zip: ______________

Authorization to Treat/Administer Medication:
I hereby authorize medical or surgical treatment of ______________________ if any emergency should arise. I give permission for decisions to be made by the certified teacher in charge and/or Madison County Schools representative.

NOTE: Your signature on this form acknowledges your acceptance of financial responsibility for any medical or dental care your child requires.

____
Signature of Parent/Guardian | Date

____
Signature of Notary | Date

____
State | County | Date Commission Expires