# 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 notifiy:

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