

**MADISON CITY SCHOOLS  
OUT OF COUNTY/OVERNIGHT FIELD TRIP FORM**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Telephone # \_\_\_\_\_  
Address \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_  
Address \_\_\_\_\_  
Mother work # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Father work # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
If unable to reach parents, please notify:  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone # \_\_\_\_\_ Cell phone # \_\_\_\_\_

**Student's General Health Information**

Madison City Schools require a Medication Release Form signed by a physician for each prescription medication and a Medication Release Form for each over-the-counter medication signed by the parent. List any medication(s) for which a Medication Release Form is already on file in the school office. Additional dosages/times must be notated on a copy of the form filed in the office and that notation verified and signed by the student's parent/guardian.

List any routine medications taken at home \_\_\_\_\_  
at school \_\_\_\_\_

Does student have any allergies to medication, food, etc.?  Yes  No

If "yes", please list allergies: \_\_\_\_\_

Does student wear contact lenses?  Yes  No

Does student have asthma?  Yes  No

Date of last tetanus shot: \_\_\_\_\_

Is there any health history that may assist the person in charge if the student should become ill? \_\_\_\_\_

Student's Physician \_\_\_\_\_ Telephone # \_\_\_\_\_

**It is the parent's responsibility to provide new/updated information.**

**All paperwork AND medications must be submitted to the proper authorities by \_\_\_\_\_ (2 weeks prior to trip).**

**Failure to follow this deadline will result in the student not participating in the field trip.**

**There is no guarantee that money will be refunded.**

**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 City School representative. I also hereby authorize Madison City Schools, or representative thereof, to administer my child medication if necessary as indicated on the Medication Release Form.

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

\_\_\_\_\_  
State

\_\_\_\_\_  
County

Commission Expires: \_\_\_\_\_