

Out of County/Overnight Field Trip Form

Student's Name: _____ Date of Birth: _____
Address: _____ Home Telephone # _____
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) that a Medication Release Form is already on file in the school office. Additional dosages/times must be noted 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 _____ . Failure to follow
(2 weeks prior to trip)
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: _____