

**Madison City Schools**  
**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?

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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: \_\_\_\_\_