

**MADISON CITY SCHOOLS**  
**OVERNIGHT OR OUT OF STATE FIELD TRIP FORM**  
**MEDICAL RELEASE FORM**

**Must be NOTARIZED**

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Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Student Cell #: \_\_\_\_\_

Parent Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Mother Cell# \_\_\_\_\_ Father Cell# \_\_\_\_\_

If unable to reach parents, please notify:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alternate #: \_\_\_\_\_

**Student's General Health Information**

The Madison City School district requires 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 student's parent/guardian. List any medications for which 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 must be verified and signed by the student's parent/guardian.

Does the student have any allergies of medication, food, etc. \_\_\_\_\_ Yes \_\_\_\_\_ No

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

Does the student wear contact lenses? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does the student have asthma? \_\_\_\_\_ Yes \_\_\_\_\_ No

If "yes" a Student Asthma Action Plan should be on file in the nurse's office.

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

\_\_\_\_\_  
\_\_\_\_\_

Student's Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

Insurance Company: \_\_\_\_\_

**Authorization of Treat/Administer Medication:**

I hereby authorize medical and/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 Schools' representative. I also hereby authorize Madison City Schools, or representative thereof, to administer medication to my child, 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 Expire