



# AUTHORIZATION FOR EMERGENCY TREATMENT AND SELF-ADMINISTRATION OF MEDICATION FOR SCHOOL-SPONSORED TRIP

## STUDENT INFORMATION

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Home phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Student's Physician \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Student's Dentist \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

## PARENT / GUARDIAN INFORMATION

PARENT/GUARDIAN #1	PARENT/GUARDIAN #2
Name _____	Name _____
Address _____	Address _____
Phone (____) _____	Phone (____) _____
Employer _____	Employer _____
Work Phone (____) _____	Work Phone (____) _____
Cell Phone (____) _____	Cell Phone (____) _____
E-mail address _____	E-mail address _____

## HEALTH CONCERNS

Allergies:  No  Yes If yes, list: \_\_\_\_\_

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

Does your son/daughter take any daily medications?  No  Yes *(please list in medication section on back of form)*

Does your son/daughter have any significant health concerns?  No  Asthma  Diabetes  Seizure Disorder

Other \_\_\_\_\_ Explain: \_\_\_\_\_

Give instructions / restrictions \_\_\_\_\_

## AUTHORIZATION FOR MEDICATION

I give permission for my son/daughter to administer his/her own medication(s) during this trip. The following medications will be sent with my son/daughter in a pharmacy-labeled container (prescription medication) or the original manufacturer's packaging (non-prescription medication).

\_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_

Date

Medication Name:	Dose: mg/cc/ tsp	Form: tab /cap / liq / inhaler	Time to be taken:	Reason:

## CONSENT FOR EMERGENCY TREATMENT

(must be fully completed for your child to travel)

If a situation occurs in which my son/daughter needs immediate medical attention and I am unavailable to give consent, this signed statement will serve as an authorization for a school representative to obtain any medical care for my son/daughter that is in his/her best interest, until I can be contacted. I understand that every effort will be made to contact me prior to initiating care. I also understand that any expenses incurred for emergency transportation and/or care are my responsibility.

\_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Alternate Emergency Contact

\_\_\_\_\_ ( ) \_\_\_\_\_

Relationship

\_\_\_\_\_

Phone

## INSURANCE SUBSCRIBER INFORMATION

Subscriber's Name \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_

24 hour access phone number ( ) \_\_\_\_\_

Subscriber's ID / Group # \_\_\_\_\_

Is this an HMO plan?  No  Yes If yes, give name and phone number of contact to obtain permission for hospital treatment? \_\_\_\_\_

## AUTHORIZATION FOR FIRST AID AND/OR COMFORT CARE

I hereby authorize **South High School** staff /chaperones to administer first aid or comfort care, if needed, to my son/daughter, during the band/choir/orchestra trip to \_\_\_\_\_

\_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_

Date