



**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 Blackshirts Band Trip to Australia, April 21-30, 2011.

Parent/Guardian Signature

Date