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 this deadline will result in the student not participating in the field trip. There is no guarantee that money will be refunded.
(2 weeks prior to trip)

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.

_____ Date:_____
Signature of Parent/Guardian

_____
Signature of Notary

_____ _____
State County

Commission Expires:_____