Madison County Schools
Out-of-Town/Overnight Field Trip Medical Release Form

Student's Name: ____________________

Street Address: ____________________

City: ____________ Zip: __________

Date of Birth: ____________________

Parent/Guardian Contact: ____________________

Address: ____________________

Home Ph #: ____________________

Work Ph #: ____________________

Cell Ph # or Pager: ____________________

If unable to reach parent/guardian, please notify:

Name: ____________________

Relationship: ____________________

Home Ph #: ____________________

Cell Ph # or Pager: ____________________

Medical Insurance Information:

Provider: ____________________

Contract #: ____________________

Group #: ____________________

Student's General Health Information:

1. Does your child take medication? YES NO
   (A completed and signed *School Medication Prescriber/Parent Authorization Form* is required for each medication (prescription or over-the-counter) to be administered during the field trip).
2. Does your child have any allergies? YES NO If yes, please list: ____________________
   Does your child require medication to treat severe allergic reactions to insect stings/bites, food, etc.? __________
   (If yes, a copy of the completed and signed *Emergency Plan for Severe Allergy* form and the form(s) for related medication(s) must accompany this form).
3. Does your child have asthma? YES NO
   (If yes, a copy of the *student Asthma Action Plan* and related medication authorization forms must accompany this form).
4. Date of your child's last Tetanus Booster shot: ____________________
5. Is there any health history that may assist the person in charge if this student should become ill? __________
   ____
   ____
   Student's Physician: ____________________
   Address: ____________________
   City: ____________ State: ____________ Zip Code: ____________

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 County Schools representative.

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 Date

____
State County Date Commission Expires