

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

Student's Name: \_\_\_\_\_

If unable to reach parent/guardian, please notify:

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

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

City: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_

Home ph #: \_\_\_\_\_

Cell ph # or Pager: \_\_\_\_\_

Parent/Guardian Contact: \_\_\_\_\_

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

Medical Insurance Information:

Home Ph# \_\_\_\_\_

Provider: \_\_\_\_\_

Work Ph# \_\_\_\_\_

Contract# : \_\_\_\_\_

Cell Ph # or Pager: \_\_\_\_\_

Group#: \_\_\_\_\_

**Student's General Health Information:**

1. Will your child need medication while on the field trip? 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 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. Does your child have diabetes? YES NO  
(If yes, a copy of the *student Plan of Care* and related medication authorization forms must accompany this form).
5. Date of child's last Tetanus Booster shot: \_\_\_\_\_
6. Is there any other health history that may assist the person in charge if this student should become ill?  
\_\_\_\_\_  
\_\_\_\_\_

Student's Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**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

