School District of Fort Atkinson Overnight Field Trip Medical Release Form

Street Address:	Student's Name:	Parent/Guardian:
Cally Call	Street Address:	Address:
Medical Insurance Information: Cell # or Pager:	City: Zip:	
Cell # or Pager:	Date of Birth:	Work #:
Medical Insurance Information: Provider:		Cell # or Pager:
Contact #:	Medical Insurance Information:	
Contact #:	Provider:	If unable to reach parent/guardian, please notify:
Relationship: Home #: Cell # or Pager: Cell #	Contact #:	Name:
Health Care Provider:	Group #:	
Student's General Health Information:	1	
Student's General Health Information: 1. Does your child take medication? YES or NO [A completed and signed Administering Medication to Student 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 or NO If yes, please list: [If your child requires medication to treat severe allergic reactions, complete the allergy section on the reverse side (Emergency Allergy/Asthma Plan.) Please note signatures required at the bottom]. 3. Does your child have asthma? YES or NO [If yes, complete the asthma section on the reverse side (Emergency Allergy/Asthma Plan.) Please note signatures required at the bottom]. 4. Is there any health history that may assist the person in charge if this student should become ill? Trip Consent/Authorization to Seek Medical Treatment: I give permission for above listed student to participate in this overnight field trip. The undersigned parents/guardians, in the event that he or she cannot be contacted through reasonable efforts, does hereby empower and grant the School District of Fort Atkinson personnel permission to consent to and authorize dental, medical and hospital care and treatment for the above student. This authorization shall be valid for the duration of the trip. I do hereby indemnify and hold harmless the physicians, hospital and other persons who act in reliance upon the authorization. NOTE: Your signature on this form acknowledges your acceptance of financial responsibility for any medical or dental care you child requires. Signature of Parent/Guardian Date	Health Care Provider:	Cell # or Pager:
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Signature of Notary Date	Signature of Parent/Guardian	Date
	Signature of Notary	Date

State

County

Date Commission Expires