School District of Fort Atkinson
Overnight Field Trip Medical Release Form

Student's Name: _____
Street Address: _____
City: _____ Zip: _____
Date of Birth: _____

Medical Insurance Information:
Provider: _____
Contact #: _____
Group #: _____

Health Care Provider: _____
City: _____ State/Zip: _____
Phone: _____

Parent/Guardian: _____
Address: _____
Home #:_____
Work #: _____
Cell # or Pager: _____

If unable to reach parent/guardian, please notify:
Name: _____
Relationship: _____
Home #: _____
Cell # or Pager: _____

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

Signature of Notary Date

State County Date Commission Expires