



**AUTHORIZATION FOR EMERGENCY TREATMENT
AND SELF-ADMINISTRATION OF MEDICATION
FOR SCHOOL-SPONSORED TRIP**

STUDENT INFORMATION

Student's Name _____ Birthdate _____

Address _____ Home phone _____

City _____ State _____ Zip _____

Student's Physician _____

Phone (____) _____

Address _____ City _____ Zip _____

Student's Dentist _____

Phone (____) _____

Address _____ City _____ Zip _____

PARENT / GUARDIAN INFORMATION

PARENT/GUARDIAN #1

Name _____

Address _____

Phone (____) _____

Employer _____

Work Phone (____) _____

Cell Phone (____) _____

E-mail address _____

PARENT/GUARDIAN #2

Name _____

Address _____

Phone (____) _____

Employer _____

Work Phone (____) _____

Cell Phone (____) _____

E-mail address _____

HEALTH CONCERNS

Allergies: No Yes If yes, list: _____

Date of last tetanus shot _____

Does your son/daughter take any **daily medications**? No Yes *(please list in medication section on back of form)*

Does your son/daughter have any **significant health concerns**? No Asthma Diabetes Seizure Disorder

Other _____ Explain: _____

Give instructions / restrictions _____

AUTHORIZATION FOR MEDICATION

I give permission for my son/daughter to administer his/her own medication(s) during this trip. The following medications will be sent with my son/daughter in a pharmacy-labeled container (prescription medication) or the original manufacturer's packaging (non-prescription medication).

Parent/Guardian Signature

Date

Medication Name:	Dose: mg/cc/ tsp	Form: tab /cap / liq / inhaler	Time to be taken:	Reason:

CONSENT FOR EMERGENCY TREATMENT

(must be fully completed for your child to travel)

If a situation occurs in which my son/daughter needs immediate medical attention and I am unavailable to give consent, this signed statement will serve as an authorization for a school representative to obtain any medical care for my son/daughter that is in his/her best interest, until I can be contacted. I understand that every effort will be made to contact me prior to initiating care. I also understand that any expenses incurred for emergency transportation and/or care are my responsibility.

Parent/Guardian Signature

Date

Alternate Emergency Contact

_____ (____) _____

Relationship

Phone

INSURANCE SUBSCRIBER INFORMATION

Subscriber's Name _____

Name of Insurance Company _____

Address of Insurance Company _____

24 hour access phone number (____) _____

Subscriber's ID / Group # _____

Is this an HMO plan? ____No ____Yes If yes, give name and phone number of contact to obtain permission for hospital treatment? _____

AUTHORIZATION FOR FIRST AID AND/OR COMFORT CARE

I hereby authorize **North High School** staff /chaperones to administer first aid or comfort care, if needed, to my son/daughter, during the band/choir/orchestra trip.

Parent/Guardian Signature

Date