# Permission for Field Trip/Medical Release Form

## *Permission for Field Trip*

**Student's Name** _____ _____ _____
***Last Name*** ***First Name*** ***Middle Initial***

**School** _____ **Grade** _____ **Homeroom/Classroom** _____

*I give permission for my child to participate in the following school-related student trip and understand that my child is required to follow Board and school policies during this school-sponsored activity.*

_____ _____
***Signature of Parent/Guardian's Signature*** ***Date***

**LIST ALL DESTINATIONS**

| | | | |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| Destination | Date | Depart time | Return Time |
| _____ | _____ | _____ | _____ |
| Destination | Date | Depart time | Return Time |
| _____ | _____ | _____ | _____ |
| Destination | Date | Depart time | Return Time |

**Mode of Transportation** _____**Cost to Student $**_____

## *Medical Release (Emergency)*

**In case of emergency, illness or accident to the above named child, while on the school-related student trip, I give consent to the nearest hospital to render medical emergency care deemed appropriate by the hospital staff. I also give consent to school personnel to take whatever action is deemed necessary in their judgement for the health of said child.**

_____ _____
***Signature of Parent/Guardian*** ***Date***

**My child HAS the following life-threatening condition that may require EMERGENCY treatment while on a field trip.**
☐ **DIABETES** ☐ **ASTHMA** ☐ **SEIZURES** ☐ **SEVERE ALLERGY**
☐ **OTHER:** _____

**If your child must take any medication while on the field trip, the back side of this form MUST be completed.**
*****RETURN TO TEACHER*****

# Permission for Field Trip/Medical Release Form

Estill County School Health Program
Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

**School:**_____ **Date form received:**_____
**I/we acknowledge receipt of this Health Care Provider's Statement and Parent Authorization.**
_____

Student Name:_____ **Student age:** _____ **Date of Birth:**_____
**Grade:**_____ **Homeroom/Classroom:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

***(MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER)***
Name of medication: _____ Reason for medication:_____
ALLERGIES:_____ Any OTHER Condition(s):_____
**Form of medication/treatment:** _____
□ **Tablet/capsule** □ **Liquid** □ **Inhaler** □ **Injection** □ **Nebulizer** □ **Other** _____
Instructions **(Schedule and dose to be given at school)** _____
_____
**Start:** □ **Date form received** □ **Other, as specified:**_____
**Stop** □ **End of school year** □ **Other date/duration:**_____
□ For episodic/emergency events only
Restrictions and/or important side effects: □ **No restrictions**
□ **Yes. Please describe:** _____
Special storage requirements: □ **None** □ **Refrigerate**
**Other Instructions:** _____
Parent or Guardian Signature _____ **Date:**_____
**Health Care Provider Name** _____
**Address:**_____ **Phone:**_____ **FAX:**_____

**I give permission for (name of child)**_____ **is to receive the above stated medication at school according to standard School Board policy. I release the School Board and its employees from any claims or liability connected with its reliance on this permission.**
By signing below, I understand that I MUST bring / send the medication in its original container.)
Date:_____ Signature:_____ Relationship:_____
Home phone:_____ Work phone:_____ Emergency or CELL phone:_____

Provider MEDICATION AUTHORIZATION

If NO Signature by a health care provider the child will be PROHIBITED from attending the field trip.

This student is capable and responsible to self-administer the above medication:
□ Yes - Unsupervised □ Yes-Supervised □ No
**This student may carry this medication:** □ Yes □ No Any restriction(s):_____
Designated, trained school personnel will assist child with the above named medication if necessary.
**Signature:**_____ **Date**_____
Health Care Provider

Review/Revised:8/17/2017