

INDEPENDENT SCHOOL DISTRICT 196  
Rosemount, Minnesota  
*Educating our students to reach their full potential*

Series Number 604.7.2.4.1P Adopted March 1982 Revised May 1999

Title Overnight Field Trip – Student Medical Treatment Information and Permission

Student's name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

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

Parent or guardian name \_\_\_\_\_

Address, if different from student \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Phone Work Phone

Name and phone of neighbor or relative \_\_\_\_\_ ( ) \_\_\_\_\_

Health care agency \_\_\_\_\_ Ins. Policy # \_\_\_\_\_

**Medical Information**

Any known allergies (including drug allergies or severe allergies to animals, foods or other substances)? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Medication student is presently taking \_\_\_\_\_  
How often \_\_\_\_\_  
Reason \_\_\_\_\_

List any physical factors that might affect student's activity or would be necessary for a physician to know when caring for your child \_\_\_\_\_

**Parental Permission**

If an emergency arises, it might be necessary to seek care for your child before staff can con-tact you. Such care can be provided only if you sign the authorization below. Either the auth-orization or a statement of the reason for not allowing it should accompany this health form.

In case of minor illness or injury, I, \_\_\_\_\_, parent or guardian of \_\_\_\_\_, give my permission for the supervisor of my child to administer necessary treatment and/or first aid.

In case of an emergency, I hereby authorize the official representative of my child's school or the person in charge of the program to permit a physician/hospital to administer emergency or surgical care, and I further authorize any licensed physician, medical facility or trained emergency technician to administer emergency or surgical care.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date