



HEALTH AND MEDICAL RELEASE FORM
LAURENTIAN AND OTHER EXTENDED DAY/OVERNIGHT FIELD TRIPS

Student Name Birth Date
Home Address
Parent/Guardian
Home Phone Business Phone Cell
Parent/Guardian
Home Phone Business Phone Cell

If unable to contact parent in an emergency, contact:

Name Phone
Name Phone

STUDENT HEALTH INFORMATION

Health Care Provider Phone
Health Insurance Carrier Policy No.
Does your child have allergic reactions to plants, insects, food, medication? No Yes
Describe:
Does your child have an Epi-pen to treat a severe allergic reaction? No Yes

Are there any health problems that make it inadvisable for your child to participate in physical activities while on the extended day/overnight activity? No Yes

Describe:

Date of most recent Diphtheria/Tetanus (Pertussis) immunization:

MEDICATION

Is the student taking medication at present? No Yes

Prescription medication/s:

The Medication Authorization Form (on reverse side) must be completed and signed by a licensed health care provider for any prescription medication administered. Medication authorizations already on file may need to be amended to cover times of administration outside the normal school day.

Non-prescription (over-the-counter) medication:

I give my permission for my child to receive the following over-the-counter medication(s). I will send medication in its original container labeled with my child's name. No medication will be administered to a student unless it has been provided by the parent.

Medication Name Reason
How much When

Medication Name Reason
How much When

EMERGENCY CARE

If a serious emergency occurs, it might be necessary for a physician to attend to your child before the staff can get in touch with you. This care can be provided only if you sign the authorization below. Either the authorization or a signed statement listing the reasons for not allowing it should accompany this health form.

I hereby authorize the official representative of my child's school, or the person in charge at the extended day facility, to provide medical or surgical care for while he/she is in attendance at the extended day activity.

Signed Date

Authorization for Administration of Medication at School



Name of Student: _____ Birthdate: ____/____/____

School: _____ School Year: _____ Grade: _____

Fax: _____

| Medical Condition | Medication | Strength | Dose | Time | Route | Possible Side Effects |
|-------------------|------------|----------|------|------|-------|-----------------------|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |

Other Considerations/Directions: _____

Start Date: _____ Stop Date: _____

(All authorizations expire at the end of the school year.)

- Student is knowledgeable about the medication and how to administer it.
- Student may carry and self-administer the medication. **(Not applicable for controlled substances.)**

Print or Type Name of Physician/Licensed Prescriber

Physician's/Licensed Prescriber's Signature

Clinic Address

() _____
Phone Number Date

() _____
Fax Number

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
 2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
 3. I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.)
 4. I give permission for the school nurse to communicate with the student's teachers about the action and side effects of this medication(s).
 5. I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
 6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
- My son/daughter may carry and self-administer his/her medication. **(Not applicable for controlled substances.)**

Date

Parent/Guardian Signature

Relationship to Student

NOTE: Medication is to be supplied in the original/prescription bottle/container.