Madison County Schools Out-of-County/Overnight Field Trip Medical Release Form

udent's Name:	If unable to reach parent/guardian, please notifiy:
reet Address:	Name:
ity:Zip	Relationship:
ate of Birth:	Home ph #:
	Cell ph # or Pager:
arent/Guardian Contact:	
ddress:	Medical Insurance Information:
ome Ph#	Provider:
Jork Ph#	Contract# :
ell Ph # or Pager:	Group#:
medication (prescription or over-the-counters) 2. Does your child have allergies? Does your child require medication to treat (If yes, a copy of the completed and signed I related medication(s) must accompany this 3. Does your child have asthma? (If yes, a copy of the student Asthma Action accompany this form). 4. Does your child have diabetes? (If yes, a copy of the student Plan of Care are form). 5. Date of child's last Tetanus Booster shot:	Prescriber/Parent Authorization Form is required for each er) to be administered during the field trip). S NO If yes, please list: Severe allergic reactions to insect stings/bites, food, etc.? Emergency Plan for Severe Allergy form and the form(s) for form). S NO Plan and related medication authorization forms must S NO Indeed related medication authorization forms must accompany this
Student's Physician:	
Address:S	Phone # State: Zip:
representative.	t of if any emergency should by the certified teacher in charge and/or Madison County Schools ses your acceptance of financial responsibility for any medical or
Signature of Parent/Guardian	Date
Signature of Notary	Date
State	unty Date Commission Expires