# Permission for Field Trip/Medical Release Form

## Permission for Field Trip

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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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

<table>
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<tr>
<th>Destination</th>
<th>Date</th>
<th>Depart time</th>
<th>Return Time</th>
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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***

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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 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