**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>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>Grade</td>
<td>Homeroom/Classroom</td>
<td></td>
</tr>
</tbody>
</table>

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.

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**Signature of Parent/Guardian’s Signature**

---

**Date**

**LIST ALL DESTINATIONS**

<table>
<thead>
<tr>
<th>Destination</th>
<th>Date</th>
<th>Depart time</th>
<th>Return Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Mode of Transportation __________________________ Cost to Student $_________

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**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.

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**Signature of Parent/Guardian**

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**Date**

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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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Page 1 of 2
Permission for Field Trip/Medical Release Form

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

<table>
<thead>
<tr>
<th>TO BE COMPLETED BY SCHOOL PERSONNEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>School: ____________________________ Date form received: ____________</td>
</tr>
<tr>
<td>I/we acknowledge receipt of this Health Care Provider’s Statement and Parent Authorization.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TO BE COMPLETED BY PARENT/GUARDIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Name: ______________________ Student age: _______________ Date of Birth: ____________</td>
</tr>
<tr>
<td>Grade: ____________________________ Homeroom/Classroom: ____________</td>
</tr>
</tbody>
</table>

***(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
d ☐ 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) __________________________ 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