AUTHORIZATION FOR EMERGENCY TREATMENT AND SELF-ADMINISTRATION OF MEDICATION FOR SCHOOL-SPONSORED TRIP

STUDENT INFORMATION

Student's Name______________________________ **Birthdate**______________

Address____

City______________________ State______________ Zip__________

Student's Physician______________________________

Phone (____)______________________

Address______________________ City______________ Zip________

Student's Dentist______________________________

Phone (____)______________________

Address______________________ City______________ Zip________

PARENT / GUARDIAN INFORMATION

PARENT/GUARDIAN #1

Name______________________________

Address______________________________

Phone (____)______________________

Employer______________________________

Work Phone (____)______________________

Cell Phone (____)______________________

E-mail address______________________________

PARENT/GUARDIAN #2

Name______________________________

Address______________________________

Phone (____)______________________

Employer______________________________

Work Phone (____)______________________

Cell Phone (____)______________________

E-mail address______________________________

HEALTH CONCERNS

Known allergies____

Date of Last Tetanus Shot______________________

Does your son/daughter have any significant health concerns? ☐ No ☐ Asthma ☐ Diabetes ☐ Seizure Disorder

☐ Other______________________ Explain:______________________________

____

Give instructions / restrictions____

____

AUTHORIZATION FOR MEDICATION

I give permission for my son/daughter to administer his/her own medication(s) during this trip. The following medications will be sent with my son/daughter in a pharmacy-labeled container (prescription medication) or the original manufacturer's packaging (non-prescription medication).

_______________________________ Parent/Guardian Signature

_______________________________ Date

Medication Name:	Dose:	Form: Tab /cap / liq / inhaler	Time to be taken:	Reason:

CONSENT FOR EMERGENCY TREATMENT

If a situation occurs in which my son/daughter needs immediate medical attention and I am unavailable to give consent, this signed statement will serve as an authorization for a school representative to obtain any medical care for my son/daughter that is in his/her best interest, until I can be contacted. I understand that every effort will be made to contact me prior to initiating care. I also understand that any expenses incurred for emergency transportation and/or care are my responsibility.

_______________________________ Parent/Guardian Signature

_______________________________ Date

_______________________ Alternate Emergency Contact

_______________________ Relationship

(____)__________________ Phone

INSURANCE SUBSCRIBER INFORMATION

Subscriber's Name ____

Name of Insurance Company_______________________________________

Address of Insurance Company______________________________________

24 hour access phone number (____)________________________________

Subscriber's ID / Group # ____

Is this an HMO plan? _____No _____Yes If yes, give name and phone number of contact to obtain permission for hospital treatment?____

AUTHORIZATION FOR FIRST AID AND/OR COMFORT CARE

I hereby authorize South High School staff /chaperones to administer first aid or comfort care, if needed, to my son/daughter, during the robotics trip to the **FIRST Championship in Atlanta, GA April 16-20**

_______________________________ Parent/Guardian Signature

_______________________________ Date