

**Whitewater Unified School District
Out-of-Town/Overnight Field Trip Medical Release Form**

Student's Name: _____
Street Address: _____
City: _____ Zip: _____
Date of Birth: _____

If unable to reach parent/guardian, please notify:
Name: _____
Relationship: _____
Home Ph # _____
Cell Ph # or Pager: _____

Parent/Guardian Contact: _____
Address: _____
Home Ph #: _____
Work Ph #: _____
Cell Ph. # or Pager: _____

Medical Insurance Information:
Provider: _____
Contact #: _____
Group #: _____

Student's General Health Information:

1. Does your child take medication? YES or NO
(A completed and signed Administering Medication to Student Form is required for each medication (prescription or over-the-counter) to be administered during the field trip).
2. Does your child have any allergies? YES or NO If yes, please list: _____
Does your child require medication or treat severe allergic reactions to insect stings/bites, food, etc? _____
(If yes, a copy of the completed and signed *Emergency Plan for Severe Allergy* form and the form (s) for related medication(s) must accompany this form).
3. Does your child have asthma? YES or NO
(If yes, a copy of the *student Asthma Action Plan* and related medication authorization forms must accompany this form).
4. Date of your child's last Tetanus Booster shot: _____
5. Is there any health history that may assist the person in charge if this student should become ill?

Student's Physician: _____
Address: _____
City: _____ State: _____ Zip code: _____

Authorization to Treat/Administer Medication:

I hereby authorize medical or surgical treatment of _____ if any emergency should arise. I give permission for decisions to be made by the certified teacher in charge and/or Whitewater Unified School District representative.

NOTE: Your signature on this form acknowledges your acceptance of financial responsibility for any medical or dental care you child requires.

Signature of Parent/Guardian Date

Signature of Notary Date

State County Date Commission Expires