MEDICAL HISTORY AND CONSENT FOR TREATMENT FOR FIELD TRIP

Name____ Date of Birth ___________________
Street/Mailing Address ____
Town _____________________________________ State___________ Zip ___________________________
Parent/Guardian ________________________ Day phone ______________________ Eve phone ______________
Address ____

ALLERGIES: Bee sting ______ Food ___________________ Drug __________________ Other ______________

Describe any physical/medical conditions ____

Any history of concussion ______Yes ______No, If yes when? ____

Name of student's physician or healthcare provider ____ ___________________________Phone _______________
Address ____

Insurance Company ______________________________________ Member number ______________________
Insurance Company Address ____

REQUIRED PARENT GUARDIAN CONSENT To the best of my knowledge, the above medical history is accurate. I understand that in the case of an emergency,every effort will be made to contact a parent or guardian prior to treatment. If a parent or guardian cannot be reached and the situation requires immediate emergency attention as determined by program staff, I hereby authorize representatives of Sturgis Charter Public School to obtain emergency treatment for my child as deemed necessary by the program representatives. Sturgis Charter Public School administrators and staff will not held liable for procedures performed pursuant to this consent.

PARENT/GUARDIAN SIGNATURE ____
Print Name ____ Date ________________________

Complete the portion below only if medication will be needed during field trip

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MEDICATIONS,PRESCRIPTION: Prescribed medications must be in its original container with pharmacy label showing the pharmacy's number, patient name, date filled ,physician name, name of medication and directions for use. Over the counter medications must be in the original packaging the name of medication and dosage clearly visible.

Please list any medications (prescription or over the counter including Epi-pens/Benadryl and inhalers) that your child may require for the duration of the program:

PERMISSION TO CARRY MEDICATIONS:
Once the Medication Consent and Order form (or the allergy action plan) has been completed, which is required for student's to be allowed to carry and/or administer all prescription medications, and the school nurse deems it appropriate, he/she will be permitted to do so. If you agree that your child is capable of carrying and/or administering his/her medication, please sign the authorization below. Also note that by signing below you grant permission to the School Nurse to delegate medication administration to your child's teacher/designee during this school trip. (If an Epi-pen is necessary the teacher/designee will be included as a delegated administrator for this medication)

PLEASE PRINT: I,____, parent/guardian of the above named student, give consent for my son/daughter to carry and/or administer the medications listed above unless otherwise specified below:

____ ______________________
Parent/guardian signature Date