Emergency Medical Release

Please complete and return form by Wednesday, August 9.

Student's Name_____DOB_____

Address_____CITY_____

State/ZIP_____

Home Phone_____

Allergies_____

Parent/Guardian_____

Work #_____Cell #_____

Emergency Contact (if parent cannot be reached)

Name/Contact #_____

If your child takes medication on a daily or as needed basis we need to know if you want him/her to take this medication while on the trip. Please include over the counter medication such as Tylenol, Motrin, Claritin, etc. It will be necessary for your child to administer their own medication while in the presence of Mrs. Pedziwater or a chaperone, as they will only be acting in a supervisory capacity. All medication must come in original container, labeled with the child's name, name of medication, and correct dosage. Mrs. Pedziwater will keep all medication.

Medication Name_____

Purpose_____

Dosage_____Frequency_____

(over)

Please provide insurance information:

Insurance Company_____Phone #_____

Policy Holder_____Policy#_____

I, the undersigned, understand and acknowledge that every effort will be made to contact the parents in case of an emergency, and if possible, before any medical treatment is administered. In the event of an emergency or if the parents cannot be reached, I hereby give permission to secure proper treatment for my child as named on this form. If necessary, this includes selection of physicians and medical treatment facility that are then authorized to perform such medical treatments as deemed necessary to protect the health of my child. In the event of any emergencies during the trip, the undersigned hereby grants authority to be exercised at the discretion of the Program Leader or chaperone to dispense over the counter medication.

I have read and agree to all rules and conditions.

_____ _____

Parent/Guardian signature **Date**