LANSING MIDDLE SCHOOL

Field Trip Medical Authorization

IMPORTANT – THIS FORM MUST BE SIGNED AND COMPLETED EACH SCHOOL YEAR FOR ALL FIELD TRIPS AND OVERNIGHT TRIPS , AND SHOULD BE UPDATED AS INFORMATION CHANGES.

Student Name _____

School Year 20____-20____

As the parent/guardian of the above named minor, I do hereby appoint Lansing Central School District chaperones, coaches, faculty, staff and assigned volunteers to act in my behalf in authorizing emergency, medical, dental, surgical care and hospitalization for the above named minor. This document shall be presented to a physician, nurse practitioner, physician's assistant, or appropriate medical/hospital representative(s) at such time as emergency care is needed.

STATEMENT OF CONSENT

I give Lansing Central School District (LCSD) chaperones, coaches, faculty, staff and assigned volunteers consent for my child to participate in any school sponsored trip held during this academic school year.

1. In case of a medical emergency, I grant the LCSD representative the right to authorize medical care, if none of the persons named below can be reached.
2. I agree to pay the expense of returning my child home before termination of the event if s/he does not adhere to the established standards of conduct.
3. The LCSD and its representatives are not responsible for damage or loss of property personally owned by my child.

(SEE REVERSE SIDE FOR MEDICAL CONCERNS, MAJOR ILLNESS, INJURY, SURGERY, ALLERGIES, CURRENT MEDICATIONS, AND CHRONIC CONDITIONS)

Child's Physician _____ Phone # (_____)_____

Insurance Company _____

Insurance ID and Group Number _____

(SEE REVERSE SIDE FOR EMERGENCY CONTACT NAMES, ADDRESSES, AND TELEPHONE NUMBERS.)

Please Print Parent's Name _____

Parent's Signature _____ Date_____

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LANSING MIDDLE SCHOOL

Field Trip Medical Information

IMPORTANT – THIS FORM MUST BE SIGNED AND COMPLETED FOR ALL FIELD TRIPS AND OVERNIGHT TRIPS, AND SHOULD BE UPDATED AS INFORMATION CHANGES.

Student Name _____Date of Birth _____ Grade _____
Home Address _____ Home Phone # (____)_____
Parent/ Guardian Name _____ Phone # (____)_____
Parent/Guardian Name _____ Phone # (____)_____
Student Lives with _____
Names of two emergency contacts that can be contacted if parents are not available during an emergency;
Name _____ Relationship _____ Phone # (____)_____
Name _____ Relationship _____ Phone # (____)_____

1. As the child's parent/guardian, the only known major illness, injury, surgery or allergy(s) including chronic conditions that I am aware of are as follows ;
   _____
   _____
2. I understand and agree it is my full responsibility to advise the school health office in writing of any changes or concerns in my child's health status prior to the trip.

NO MEDICATION, INCLUDING ALL OVER-THE-COUNTER NON-PRESCRIPTION MEDICATIONS MAY BE GIVEN TO YOUR CHILD WHILE ON THE FIELD TRIP OR IN SUMMER SCHOOL WITHOUT WRITTEN PERMISSION OF THE PARENT/GUARDIAN AND WITHOUT A PHYSICIAN'S SIGNED MEDICATION ORDER.

If a current medication order is on file at the School Health Office, and the medication is stored in the Health Office, the medication be sent on the field trip. Any NEW medication needs a written and signed order from the physician and must have signed permission from you as parent/guardian. Both the physician and parent must indicate if the student can self-medicate.

3. My child will be taking :
   Medication _____ Dose _____ Frequency _____
   Medication _____ Dose _____ Frequency _____

IF EMERGENCY TREATMENT IS NECESSARY, YOUR CHILD WILL BE TRANSPORTED BY THE STAFF AND/OR AMBULANCE TO THE NEAREST HOSPITAL. PARENTS WILL BE CONTACTED AS SOON AS POSSIBLE IN CASE OF ILLNESS, INJURY OR ACCIDENT. **I GIVE PERMISSION FOR THE ATTENDING PHYSICIAN TO GIVE EMERGENCY TREATMENT OF MY CHILD.**

Parent's Signature _____ **Date** _____

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