STUDENT OVERNIGHT TRAVEL
EMERGENCY AND MEDICATION FORM

Date/Duration of Travel:_____

Student Name: _____ Home Phone: _____

Address:_____ City:_____ State: _____ Zip: _____

Father/Guardian Name: _____ Work Phone: _____ Cell Phone: _____

Mother/Guardian Name: _____ Work Phone: _____ Cell Phone: _____

If I am unavailable in the event of an emergency, the following people may make decisions on my behalf and/or assume temporary custody if necessary:

Local friend or relative	Relationship	Home Phone	Work Phone	Pager/Cell

Physician: _____ Phone: _____ Hospital Preference: _____

- Do you authorize a certified district employee or Principal's designee to give your child acetaminophen (non-aspirin substitute)? **Yes_____ No_____**
- Specify health problems/allergies_____
- Is your child on daily medication? No_____ Yes_____ (If yes, complete consent for giving medication below.)
- Limitation, concerns or other information: _____
- Insurance Carrier:_____ Group Number: _____

MEDICAL TREATMENT AUTHORIZATION:

In the event of illness or injury occurring to my child while on this travel/activity, I hereby give my consent for medical or dental care deemed necessary by the attending health care provider or dentist. My child may be examined and any necessary procedures (medical, dental or surgical), anesthesia, or diagnostic procedures (lab or x-ray) may be performed under the supervision of a member of the hospital or medical office staff furnishing such services. I further acknowledge that I am financially responsible for any medical, dental, ambulance, or other health care expenses or transportation of my child home, which might occur as a result of such illness or injury. I understand that Mesa Public Schools does not provide accident medical/dental coverage for students for injuries/illnesses occurring during travel/activities. I also acknowledge that I may obtain accident insurance through Risk Management if I do not currently have family medical insurance. I understand that, in the event of other than minor illness or injury, reasonable effort will be made to contact me.

CONSENT FOR GIVING MEDICATION:

I hereby request and give my consent for a certified district employee or principal's designee to see that my child receives the medication as listed below:

MEDICATION	DOCTOR	DIAGNOSIS/ REASON FOR GIVING	TIME TO BE GIVEN	DATE FROM	DATE TO

Prescription medication must be in the original container as prepared by a pharmacist and labeled, including the patient name, name of medication, dosage and time to be given. Any over-the-counter medication must be in the original packaging with all directions, dosages, compound contents and proportions clearly marked.

Signature of Parent/Guardian_____**Date**_____

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