Mounds View
PUBLIC SCHOOLS

HEALTH AND MEDICAL RELEASE FORM
LAURENTIAN AND OTHER EXTENDED DAY/OVERNIGHT FIELD TRIPS

Student Name _____ Birth Date _____
Home Address _____
Parent/Guardian _____
Home Phone _____ Business Phone _____ Cell _____
Parent/Guardian _____
Home Phone _____ Business Phone _____ Cell _____
If unable to contact parent in an emergency, contact:
Name _____ Phone _____
Name _____ Phone _____

STUDENT HEALTH INFORMATION

Health Care Provider _____ Phone _____
Health Insurance Carrier _____ Policy No. _____
Does your child have allergic reactions to plants, insects, food, medication? No _____ Yes _____
Describe: _____
Does your child have an Epi-pen to treat a severe allergic reaction? No _____ Yes _____

Are there any health problems that make it inadvisable for your child to participate in physical activities while on the extended day/overnight activity? No _____ Yes _____
Describe: _____
Date of most recent Diphtheria/Tetanus (Pertussis) immunization: _____

MEDICATION

Is the student taking medication at present? No _____ Yes _____

Prescription medication/s:

The Medication Authorization Form (on reverse side) must be completed and signed by a licensed health care provider for any prescription medication administered. Medication authorizations already on file may need to be amended to cover times of administration outside the normal school day.

Non-prescription (over-the-counter) medication:

I give my permission for my child to receive the following over-the-counter medication(s). I will send medication in its original container labeled with my child's name. **No medication will be administered to a student unless it has been provided by the parent.**

Medication Name _____ Reason _____
How much _____ When _____

Medication Name _____ Reason _____
How much _____ When _____

EMERGENCY CARE

If a serious emergency occurs, it might be necessary for a physician to attend to your child before the staff can get in touch with you. This care can be provided only if you sign the authorization below. Either the authorization or a signed statement listing the reasons for not allowing it should accompany this health form.

I hereby authorize the official representative of my child's school, or the person in charge at the extended day facility, to provide medical or surgical care for _____ while he/she is in attendance at the extended day activity.

Signed _____ Date _____

Authorization for Administration of Medication at School

Mounds View PUBLIC SCHOOLS

Name of Student:_____ Birthdate:____/____/____

School:_____School Year:_____Grade:_____

Fax: _____

Medical Condition	Medication	Strength	Dose	Time	Route	Possible Side Effects
1						
2						
3						
4						

Other Considerations/Directions:_____

Start Date:_____ Stop Date:_____

(All authorizations expire at the end of the school year.)

❑ Student is knowledgeable about the medication and how to administer it.
❑ Student may carry and self-administer the medication. **(Not applicable for controlled substances.)**

_____ _____
Print or Type Name of Physician/Licensed Prescriber Physician's/Licensed Prescriber's Signature

_____ (___)_____ _____
Clinic Address Phone Number Date

(___)_____
Fax Number

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.)
4. I give permission for the school nurse to communicate with the student's teachers about the action and side effects of this medication(s).
5. I give permission for the school nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

❑ My son/daughter may carry and self-administer his/her medication. **(Not applicable for controlled substances.)**

_____ _____ _____
Date Parent/Guardian Signature Relationship to Student

NOTE: Medication is to be supplied in the original/prescription bottle/container.

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