Madison County Schools
Out-of-County/Overnight Activity Medical Release Form

Student:

Name	Date of Birth	Street Address	City, State	Zip Code

Parent:

Name	Home Phone	Work Phone	Cell Phone

Emergency Contact:

Name	Relationship	Home Phone	Work Phone	Cell Phone

Physician:

Name	Street Address	City, State	Zip Code	Phone

Insurance Information:
(Optional)

Provider	Contract or ID #	Group #

A completed and signed *School Medication Prescriber/Parent Authorization Form* is required for each medication, prescription or over-the-counter, to be administered while your child is participating in such events and/or activities.

If your child has a *School Health Management Plan* for a chronic health condition on file with his/her School Nurse, a copy of that plan should accompany this form and be in the possession of the Madison County Schools employee serving as the event/activity sponsor or coach.

GENERAL STUDENT HEALTH INFORMATION:

1. Will your child require medication while participating in this event or activity? ☐ YES ☐ NO
2. Does your child have allergies? ☐ YES ☐ NO If yes, please list: _____
3. Does your child require medication to treat a severe allergic reaction? ☐ YES ☐ NO
   If yes, please list all possible triggers related to your child's severe allergy: _____
4. Does your child have asthma? ☐ YES ☐ NO Does he/she use an inhaler? : ☐ at school ☐ at home or ☐ both
5. Does your child have diabetes? ☐ NO ☐ YES (If "yes", ☐ Type I or ☐ Type II?)
6. Date of your child's last Tetanus Booster: _____
7. Is there any other health history that may assist the event/activity sponsor or coach in the event your child becomes ill or is injured?
   _____
   _____

Authorization to Share Personally Identifiable and Medical Information:

I hereby authorize the Madison County Schools representative serving as my child's activity sponsor, coach, or School Nurse, to release to the Team Physician, Athletic Trainer or other medical personnel, personally identifiable and medical information pertinent to the care of my child during his/her participation in a school-sponsored event or activity.

_____

Signature of Parent/Custodian Date

Authorization to Treat/Administer Medication:

I hereby authorize medical or surgical treatment of my child in the event of an emergency. I give permission for decisions to be made by the Madison County Schools representative serving as my child's activity sponsor or coach. NOTE: Your signature on this form acknowledges your acceptance of financial responsibility for any medical or dental care your child requires.

_____

Signature of Parent/Guardian Date

_____

Signature of Notary Date

_____

State County Date Commission Expires

FEB2013