**IRONDALE MARCHING KNIGHTS - HEALTH AND MEDICAL RELEASE FORM**
**FOR EXTENDED DAY/OVERNIGHT FIELD TRIPS & ACTIVITIES**

***All permissions expire at the end of the school year.***

Student Name _____ Birth Date _____
Home Address _____ Home Phone _____
Parent(s)/Guardian(s) Name _____ Cell Phone _____
Parent(s)/Guardian(s) Name _____ Cell Phone _____

***If unable to contact parent in an emergency, contact:***

Name _____ Cell Phone _____
Name _____ Cell Phone _____

**STUDENT HEALTH INFORMATION**

Health Care Provider _____ Phone _____
Health Insurance Carrier _____ Policy No. _____
Does your child have allergic reactions to plants, insects, foods, medication? Yes No
Describe: _____
Does your child have an Epi-pen to treat a severe allergic reaction? Yes No
Describe: _____
Are there any health problems that make it inadvisable for your child to participate in any activities while on the extended day/overnight activity? Yes No
Describe: _____
Date of most recent Diphtheria/Tetanus (Pertussis) immunization: _____

**MEDICATION**

Is your child taking prescription medication at present? Yes No

**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 permission for staff and/or booster chaperone to administer the over-the-counter medications I have circled 'Yes' to, to my child. Child must notify an adult, and request medication.

- Pain reducers/Fever reducers containing acetaminophen (Tylenol) Yes No
- Pain reducers/Fever reducers containing ibuprofen (Advil) Yes No
- Decongestants containing pseudoephedrine hydrochloride (Sudafed) Yes No
- Antihistamines containing diphenhydramine (Benadryl) Yes No
- Antihistamines containing loratadine (Claritin) Yes No
- Stomach remedies containing loperamide HCl (Imodium) Yes No
- Stomach remedies containing bismuth subsalicylate (Pepto-Bismol) Yes No
- Stomach remedies containing calcium carbonate (Tums) Yes No
- Cough suppressants with guaifenesin USP or dextromethorphan hydrobromide (Robitussin) Yes No
- Topical antibiotic ointments containing bacitracin zinc (Neosporin, Bacitracin) Yes No

Parent/Guardian Signature _____ Date _____

**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. **If you do not sign the authorization below, a signed statement listing the reasons for not allowing it must accompany this health form.**

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

Parent/Guardian Signature _____ Date _____

**OVER**

Mounds View PUBLIC SCHOOLS

# HEALTH AND MEDICAL RELEASE FORM
# AUTHORIZATION FOR MEDICATION ON EXTENDED DAY/ OVERNIGHT FIELD TRIPS & ACTIVITIES

***All permissions expire at the end of the school year.***

Name of Student: _____ Birthdate: _____

School: _____ School Year: _____ Grade: _____

**NOTE: Medication must be supplied in the original/prescription bottle/container.**

| Medical Condition | Medication | Strength | Dose | Time | Route | Child can carry & self-administer | Possible Side Effects |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |

Other Considerations/Directions: _____

____ Student is knowledgeable about the prescription medication and how to administer it.

____ Student may carry and self-administer the medication as noted above. **Not applicable for controlled substances.**

_____ _____

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

_____ _____ _____

Clinic Address Phone Number Date

## 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.
2. I request the above prescription medication(s) be given on out-of-town field trips, as prescribed.
3. I am responsible to administer prescription medication to my child during extended day practices and in-town competitions.
4. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
5. I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.).
6. I give permission for the school nurse to communicate with the student's teachers or activity director about the action and side effects of this medication(s).
7. 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).
8. 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 as noted above. (Not applicable for controlled substances.)

_____ _____ _____

Date Parent/Guardian Signature Relationship to Student