

Dryden Middle School

School Health Services



PERMISSION FOR MEDICAL TREATMENT FORM  
FIELD TRIPS

Student Name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

TO WHOM IT MAY CONCERN: I, the undersigned, being the parent, legal next of kin, or legal guardian of \_\_\_\_\_, hereby authorize any necessary medical treatment for this person while participating in the \_\_\_\_\_ Trip. I guarantee payment for services rendered.

MEDICAL INSURANCE CARRIER: \_\_\_\_\_

CONTRACT NUMBER: \_\_\_\_\_

HEALTH CONCERNS

1. Allergies:  Food (please state specifics): \_\_\_\_\_  Bee  Latex

Medication  None  Other: \_\_\_\_\_

Do you carry Epinephrine?  Yes  No

2. Asthma:  Yes  No Do you carry an inhaler?  Yes  No

3. Diabetes:  Yes  No Attach instructions as needed.

4. Special medical problems. (If none, please state) \_\_\_\_\_

5. Does participant require medication that needs to be given during the course of the day?  
(If none, please state) \_\_\_\_\_

6. Family Physician or Healthcare Provider: \_\_\_\_\_

7. Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

8. Family Dentist: \_\_\_\_\_

**Please print:**

PARENT/GUARDIAN NAME: \_\_\_\_\_

PARENT (S) ADDRESS: \_\_\_\_\_

Parent 1: PHONE - Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent 2: PHONE - Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

My son/daughter has my permission to be a part of this trip.  
It is understood that he/she will be subject to all rules, regulations, and supervision of the chaperones.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_