School District of Cambridge
Telephone (608) 423-3261 Fax (608) 423-9869
Website: www.cambridge.k12.wi.us

Overnight Field Trip Medical Release Form

Name of Trip: _____
Date(s) Attending: _____

Student's Name: _____
Address: _____ City: _____ Zip: _____
Name of Parents or Guardians: _____
Telephone: (Home) _____ (Work)_____ (Cell)_____
Family Doctor Name: _____Telephone: _____
Hospital preference (if needed): _____
If parents/guardian are **not** available in case of an emergency, notify:
Name:_____Telephone:_____
Relationship to child: _____

We hereby give our consent for our child to attend _____ field trip on _____. The information on this document will be needed in order to provide a safe trip.

Student's General Health Information:

1. Does your child take medication? YES or NO
Will your child require medication during this trip? YES or NO
[A completed and signed ***Administering Medication to Student Form*** is required for each medication (prescription or over-the-counter) to be administered during the field trip.]
2. Does your child have any **allergies**? YES or NO If yes, please list:_____
[If your child requires **medication to treat severe allergic reactions,** complete be sure the school has an Emergency Allergy/Asthma Plan on file]
3. Does your child have **asthma**? YES or NO
[If YES please be sure the school has an Emergency Allergy/Asthma Plan on file]
4. Is there any health history that may assist the person in charge if this student should become ill?

_____
_____
_____
_____

5. Other Medical Information
Medical Conditions: _____
Dietary Needs: _____

Medication Notice
All prescription and non-prescription medications needed by students must be turned into the **main office** prior to the overnight field trip**.** They will be kept and administered by the trained school staff as directed. In special instances (bee sting, allergy, asthma) certain medications may stay with the students AFTER the School Nurse has checked them in.

Each medication container must be clearly labeled with the student's name, name of medication, dosage, and frequency of dosage (specific times are preferable.) All over-the-counter medications must come in their original manufacture's container with original label.

Trip Consent/Authorization to Seek Medical Treatment:

I give permission for above listed student to participate in overnight field trips. The undersigned parents/guardians, in the event that he or she cannot be contacted through reasonable efforts, does hereby empower and grant the School District of Cambridge personnel permission to consent to and authorize dental, medical and hospital care and treatment for the above student. This authorization shall be valid for the duration of the current school year. I do hereby indemnify and hold harmless the physicians, hospital and other persons who act in reliance upon the authorization. NOTE: Your signature on this form acknowledges your acceptance of financial responsibility for any medical or dental care your child requires.

Insurance Information

Name of Health Insurance:_____Subscriber number:_____
Effective Date:_____ Group Number:_____

Parent/Guardian Signature: _____ Date: _____
Updated 1-13-23