Detroit Public Schools Community District

Student Field Trip Emergency Medical Authorization Consent Form

School: ____ Grade: ________

Description of Field Trip/Activity: ____

Destination: ____

Field Trip Travel Date(s) Departure: ____________________ Return: _________________

General Information:

Student Name: ____Date of Birth _____/_____/______

Parents/Guardian: ____Home Phone (____) ______________

Home Address: _______________________________Cell/Emergency Phone: (_____) ________________

Medical History:

Does student have diabetes, epilepsy, allergies or other health problems? _____ No ____ Yes

If yes, please specify ____

Is student currently taking any medication (include antihistamines, aspirin, tranquilizers, insulin)?
____ No ____ Yes If yes, please specify ____

Is student currently under medical treatment? __ No __ Yes

If yes, please specify ____

Physician: ____

Physician Office Phone: (_____) __________________ Physician Emergency/Cell Phone: (_____) ______________

Healthcare Provider**:** ____________________________ Policy # _________________Group #______________

Parent or Legal Guardian Consent:

I (we) hereby give permission for the above-named student to be treated by a physician or licensed nurse at a hospital or on the scene in the event of a medical emergency. I (we) understand that the director, staff, chaperones, escort and/or medical personnel will be acting in the best interest of my (our) child, and I (we) will not hold them responsible for any decisions they make. I am signing this agreement voluntarily with full knowledge of its significance and intend by my signature to be a complete and unconditional release of all liability to the extent permitted by law.

Parent/Guardian Name (Print) ____

Parent/Guardian Signature (s) ____

Today's Date: ____________________