

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

Student:

Name	Date of Birth	Street Address	City, State	Zip Code
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Parent:

Name	Home Phone	Work Phone	Cell Phone
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Emergency Contact:

Name	Relationship	Home Phone	Work Phone	Cell Phone
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Physician:

Name	Street Address	City, State	Zip Code	Phone
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Insurance Information:

(Optional)

Provider	Contract or ID #	Group #
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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
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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
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Signature of Notary	Date
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State FEB2013	County	Date Commission Expires
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