MEDICAL RELEASE FORM-LCPS OUT-OF-STATE TRIPS

A Doctor's Certificate is **NOT** required. (This form is to be completed by parent/guardian-regardless of your age)

STUDENT NAME:_____ AGE:_____ D.O.B._____

SS#:_____

Student taking any medication? YES_____ NO _____ If yes, list below:

_____

Immunization History: (Give date of most recent booster dosage)
DPT _____ Tetanus _____ Small Pox _____ Polio _____

Measles _____ Mumps _____ Any other_____

Does student get motion sickness? YES _____ NO _____

If yes, provide Dramamine, etc. and list dosage to be taken _____

_____

Does student have any dietary restrictions or considerations that we need to be aware of: (Religious, allergies, vegetarian, etc.):_____

_____

MEDICAL INSURANCE COMPANY COVERING STUDENT:_____

POLICY NUMBER:_____ GROUP: _____

PRIMARY INSURED MEMBER'S NAME:_____

EMPLOYER OF PRIMARY INSURED MEMBER:_____
PHONE NUMBER _____

SOCIAL SECURITY OF PRIMARY INSURED MEMBER:_____

IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE DIRECTOR/ CHAPERONES TO SECURE PROPER MEDICAL TREATMENT, AND IF NECESSARY, TO TRANSPORT BY AMBULANCE, HOSPITALIZE, AND TO ORDER INJECTION, ANESTHESIA OR SURGERY FOR MY CHILD LISTED ON THIS FORM.

PARENTS'/GUARDIANS' NAME:_____
PLEASE PRINT

PARENTS'/GUARDIANS' SIGNATURE:_____ DATE: _____

_____ DATE:_____

HOME PHONE: _____ WORK PHONE: _____

NEAREST RELATIVE NAME:_____ PHONE:_____

STUDENT/FAMILY IS RESPONSIBLE FOR ALL MEDICAL COST INCURRED DURING THIS TRIP!

STUDENT SIGNATURE: _____ DATE:_____

WITNESS SIGNATURE: _____ DATE:_____

Form #119
8/98