

**Huntsville City Schools**  
**Out of County/Overnight Student Trips Medical Release Form**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_

Parent/Guardian #1 _____	Parent/Guardian #2 _____
Address: _____	Address: _____
Home Phone #: _____	Home Phone #: _____
Phone # @ Work: _____	Phone # @ Work: _____
Employer: _____	Employer: _____
Cell Ph. # or Pager: _____	Cell Ph. # or Pager: _____
Health Insurance: _____	Effective Date: _____
Contract Number: _____	Group Number: _____

If unable to reach parent/guardian, please notify:  
 Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
 Home Ph. #: \_\_\_\_\_ Cell Ph. # or Pager: \_\_\_\_\_

Student's General Health Information:	
1.	<b>List your child's <i>daily</i> medications: (doses and times of administration)</b>
	(1) _____
	(2) _____
	(3) _____
	(4) _____
2.	<b>List any <i>Emergency and PRN</i> medications OTC or prescribed for your child and the circumstances under which they are to be given.</b>
	(1) _____
	(2) _____
	(3) _____
	A completed and signed <i>School Medication Prescriber/Parent Authorization Form 107-11P Appendix A</i> is required for each medication –prescription or over-the-counter (OTC). <b>On file at school?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<b>List student's health conditions requiring procedures or medication; i.e. Asthma, Environmental, Seasonal Food allergies (Be specific), Diabetes, Seizures, etc.</b>
	(1) _____
	(2) _____
	(3) _____
4.	<b>An Individual Health Care Plan (IHP) is on file at school</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
	IHP is for: _____
5.	<b>Does your child wear contact lenses?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
6.	<b>Date of your child's last Tetanus Booster shot:</b> _____
7.	<b>List any health history that may be helpful if your child becomes ill.</b>
	_____
	_____

**Family Physician:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Authorization to Treat/Administer Medication:**

I hereby authorize medical and/or surgical treatment of : \_\_\_\_\_ In an emergency, I give permission for decisions to the certified teacher in charge and/or Huntsville City Schools representative.

\_\_\_\_\_  
 Signature of Parent/Guardian Date: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Notary Date: \_\_\_\_\_

State \_\_\_\_\_ County \_\_\_\_\_ Date Commission Expires: \_\_\_\_\_

\* Parent is responsible for updating this form  
 \*Signature of Parent on this form acknowledges their financial responsibility for medical and dental care when required for their child.

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