Catalina Foothills School District
Medical Consent and Release Form

Student's Name _____ **DOB:** _____

In the event of illness or injury, I agree to any emergency treatment deemed necessary by the medical personnel designated by the school authorities. Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, X-ray examinations and immunizations for the above named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given.

Signature _____ Date _____
(parent or guardian)

IF WE NEED TO CONTACT YOU:

Name of Father: _____ Name of Mother: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Name and phone number of friend or relative who could locate you in an emergency:

Name: _____ Phone: _____

Child's doctor: _____ Phone: _____

The student named above has medical insurance. Yes _____ No _____

Insurance Carrier: _____ Policy No. _____

MEDICAL INFORMATION:	YES	NO	IF YES, explain; contact Nurse, Teacher, Sponsor
Allergies	____	____	_____
Asthma	____	____	_____
Seizures	____	____	_____
Diabetes	____	____	_____
Other health concerns	____	____	_____

Please check the medications you give permission for your child to receive through the Teacher, Sponsor per original bottle instructions:

YES	NO		
____	____	Tums tablet – 2 tablets by mouth	
____	____	Acetaminophen (generic Tylenol) 12+ yrs. 325-650 mg every 4 hrs	
____	____	Ibuprofen – 200 mg tablets	< 75 lbs.: 200-400 mg every 6-8 hrs ; >75 lbs.: 400 mg every 6-8 hrs
____	____	Cough Drops	

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Medical Consent and Record Form

All medications must be given to the teacher/sponsor in the original prescription or over-the-counter (OTC) container labeled with the student's name, with only the amount needed for the duration of the trip. Medications and consent form are to be given to teacher/sponsor 1 week prior to the trip. An updated form must be completed per trip, as medications, dosages and contact information may change. **If OTC dose is greater than recommended on bottle, a physician's prescription is required.**

Student Name_____ **DOB:**_____ **Grade:**_____

1st Medication_____ Amt. Received: ____ Amt. Returned ____ Parent Initial ____

Dosage_____

Time (s) to be given_____/_____/_____OR as needed, per bottle or inhaler directions.

To be Completed by Teacher/Sponsor: _____
Teacher/Advisor Signature

	Date	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

2nd Medication_____ Amt. Received: ____ Amt. Returned ____ Parent Initial ____

Dosage_____

Time (s) to be given_____/_____/_____OR as needed, per bottle or inhaler directions.

To be Completed by Teacher/Sponsor: _____
Teacher/Advisor Signature

	Date	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

3rd Medication_____ Amt. Received: ____ Amt. Returned ____ Parent Initial ____

Dosage_____

Time (s) to be given_____/_____/_____OR as needed, per bottle or inhaler directions.

To be Completed by Teacher/Sponsor: _____
Teacher/Advisor Signature

	Date	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

4th Medication_____Amt. Received: ____ Amt. Returned ____ Parent Initial ____

Dosage_____

Time (s) to be given_____/_____/_____OR as needed, per bottle or inhaler directions.

To be Completed by Teacher/Sponsor: _____
Teacher/Advisor Signature

	Date	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

5th Medication_____Amt. Received: ____ Amt. Returned ____ Parent Initial ____

Dosage_____

Time (s) to be given_____/_____/_____OR as needed, per bottle or inhaler directions.

To be Completed by Teacher/Sponsor: _____
Teacher/Advisor Signature

	Date	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital	Time	Given By: Inital
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									

I understand that all prescription and OTC medication is to be furnished by me in the **original container with the original label.**

Parent/Guardian Signature: _____

Health offices will provide needed student medication from the health office supplies for day field trips.

Parents will provide needed student medication (including OTC) from home for overnight trips.

NOTARIZATION REQUIRED FOR OUT OF STATE AND INTERNATIONAL TRIPS.

Sworn and subscribed to before me _____of the County of _____

State of Arizona, this _____day of _____, 20___.

_____
Signature of Notary

My commission expires: _____