School:______________

Group:______________

Date of Trip:__________

WAPAKONETA CITY SCHOOL
FIELD TRIP MEDICAL RELEASE FORM

Student's Full Legal Name______________________________ **Date of Birth**______________

Home Address:______________________ **City:**________________ **State:**______ **Zip:**__________

Parent/Guardian #1 Name :______________________ **Cell Phone #:**______________________

Parent/Guardian #2 Name:______________________ **Cell Phone #:**______________________

Emergency Relative Name:______________________ **Cell Phone #:**______________________

Emergency Physician:______________________ **Phone#:**______________________

In case of emergency involving my child, if an emergency contact cannot be contacted, I authorize any employee associated with Wapakoneta City Schools to obtain temporary care of my child.

To help us plan a safe and healthy school experience for your child, please list any health concerns or medical conditions of which we should be aware.

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Does your child have any allergies (i.e. bee stings, non-prescription medication, food, etc.) If so, please list below the allergy, reaction, and medication, if any, to be given in the event of exposure.

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List all medications that the student will need to bring on the trip. Please include daily medications as well as rescue or as needed medications suce as Epi-pens, inhalers, migraine medications, etc. (Include the medication name and dosage schedule)____

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With parental/guardian permission, the over-the-counter medication listed below may be administered at the request of the student for common complaints. It will be dosed according to package directions by the nurse or an authorized school staff member. Please check any or all of the following non-prescription medications that the nurse or authorized staff have permission to administer as needed per student request.

Ibuprofen -Yes____ No____ **Tylenol** -Yes___ No___ **Dramamine** -Yes____ No____ **Benadryl**-Yes____ No____

Midol -Yes____ No____ **Claritin**-Yes____ No___ **Other**________________

(All over-the-counter medications will be provided by WCS. DO NOT SEND ANY OF THE ABOVE OVER-THE- COUNTER MEDICATIONS WITH YOUR STUDENT.)

PLEASE NOTE:
All Medication, both prescription and over the counter, must be kept and administered by the school nurse or authorized school staff member. Students are NOT permitted to transport, store or self-administer medication during this school event.

Parent/Guardian Signature:______________________________ **Date:**______________________

Please Print Name:______________________________ **WCS Nurse Initials:**__________**Date:**______