LaMuth Middle School 7th Grade Chicago Trip

6700 Auburn Road Painesville OH 44077

Phone 440-354-4394 Ext 8504 Fax 440-354-8218

STUDENT'S NAME ____ DATE OF BIRTH ____________________

Address: ____

Allergy to any food or medication: ____

To anything else (seasonal, animal, stings) ____

Does this student self-carry inhaler? _____Yes _____No Inhaler kept in the clinic? _____Yes _____No

Does this student self-carry Epi-Pen? _____Yes _____No Epi-Pen kept in the clinic? _____Yes _____No

Any medication taken on the Chicago trip prescription or over-the-counter must have a doctor's signature. Medications taken at home on a daily basis AND over-the-counter that is necessary to take on the trip will be clearly written below and on the medication envelope.

Name of Medication, dose and time to be given.

1. ____

2. ____

Special instructions for administration of medication (storage, with food, etc):

____

Any possible reactions that, if they occur, should be reported to the physician:

____

This medication can be safely administered by non-medical personnel _______ Yes _____ No

PHYSICIANS SIGNATURE ____ Date _____________

PHYSICIANS PHONE NUMBER ___________________________________

This medication form is only valid for the Chicago trip May 9-11-2018

Please regard my signature below as my assurance that I release Riverside schools, PSI, and any or all of the school's and PSI officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions and they have been answered to my satisfaction.

PARENT/GUARDIAN SIGNATURE ___________________________________ Date ______

*More information required on BACK of this form

Current Medical History ____

Medication your child takes daily ____

Recent illness or injury? ____

Additional information about the students health in which we may need to be aware of:

____

____

TO GRANT CONSENT In the event reasonable attempts to contact me at:

Parent #1 Name ________________________________ Home Phone ______________________

Work Phone ______________________________ Cell Phone_____________________________

Parent #2 Name ________________________________Home Phone________________________

Work Phone _____________________________ Cell Phone ______________________________

Contacts have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary including Permission to transport my child to the nearest hospital. This authorization does not cover major surgery unless the medical opinion of Two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Doctors Name ____ Phone ______________________________

Dentist Name ____ Phone ______________________________

Or, in the event the designated practitioner is not available, by another licensed physician or dentist.

SIGNATURE OF PARENT/GUARDIAN

____

Address- IF DIFFERENT FROM STUDENT

____