

Marion County School District

MEDICAL INFORMATION

Emergency medical authorization

Should it be necessary for my child to have emergency medical treatment while participating in this trip, I hereby authorize personnel to use their judgment in obtaining emergency medical services for my child. I further authorize any individual selected by Marion County School District personnel to render such emergency medical treatment to my child as he/she may deem necessary and appropriate. I understand that the district has no district insurance which pays the medical or hospital costs that might be incurred on behalf of my child. Consequently, I understand that any and all such costs will be my sole responsibility and I hold the district and its personnel harmless for any and all accidents which may occur during this trip or be incurred by my child as a result of attendance on this trip.

Parent/Legal guardian please complete.

_____ (Student's name)	_____ (Parent/Legal guardian)
_____ Address	_____ Home/Cell phone
_____ Business phone	_____ Additional contact/emergency numbers
_____ Health insurance carrier and policy #	_____ Primary physician and phone number

_____ **Check here if special instructions regarding medical treatment are on file in the school office.**

Is your child required to take any medication or drug during the day?

Please list here, the medication and when taken:_____

Please note or comment on any allergies or special needs your child has on the line below.
