

THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA
1960 LANDINGS BLVD., SARASOTA, FL 34231
PHONE (941) 927-9000

EMERGENCY MEDICAL/TREATMENT FIELD TRIP CONSENT

Instructions: Return completed form to your child's school. If you have questions pertaining to this form, contact your child's school.

Date _____

Student Name _____ DOB _____
Last First Middle

Home Address _____
Street City Zip

Parent/Guardian _____ Relationship _____

Address of above (if different) _____
Street City Zip

Home Phone _____ Work Phone _____ Cell Phone _____

List a person other than the parent or guardian who could be contacted in case of emergency below

Emergency Contact _____ Phone _____

Is above student allergic to foods, medications, or insects? ____ Yes ____ No

If Yes, list what they are and emergency medication/treatment, if any. _____

Does the above student have any chronic medical problems (such as asthma, diabetes, seizures)? ____ Yes ____ No

If Yes, list and describe medical requirements for field trip _____

Does the above student take any daily medication(s)? ____ Yes ____ No

If Yes, complete the medication treatment authorization form (if not previously on file in the school Health Room) and list the medication(s) and time to be administered _____

Family Physician _____ Physician Phone _____

In case of serious illness or injury where immediate care is needed, the school or its representative has my permission to contact the appropriate emergency medical service. The emergency medical service has my consent to provide necessary treatment or transportation for my child. I then request that I be notified of the situation. The undersigned will be responsible for emergency treatment cost.

In the case of an accident or illness where immediate treatment of my child is not indicated, but where (s)he is unable to remain at the field trip, I request that the school contact me or my designee to arrange transportation for my child. If the school is unable to contact me, I request that the other person listed on this form be contacted and requested to care for my child. I understand that I must notify the school if there are any changes in this health emergency information.

In case of non-life threatening emergency, list hospital preference _____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

Distribution: Original – Office

Yellow – Teacher