

INDEPENDENT SCHOOL DISTRICT 276
Minnetonka High School Activities Department
Minnetonka, MN 55345

Overnight Field Trip – Student Medical Treatment Information and Permission Form

Coach/Advisor to complete prior to handing out:

Sport/Activity: Wrestling Trip **Dates:** Thursday, December 18 – Friday, December 19 **Destination:** Rochester, MN
Lodging: Dec. 18, Centerstone Plaza Rochester, MN, (507) 292-7337, <http://www.soldiersfield.com/>
Coach/Advisor Contact Number Josh Frie (612) 865 - 9303

Parent or Guardian to complete:

Student's name _____ Age _____
Address _____ Phone (____) _____
City _____ Zip _____

Parent or guardian name _____
Address, if different from student _____
City _____ Zip _____ (____) (____) (____)
Cell Phone Home Phone Work Phone

Emergency contact other than parent _____
Name Phone

Healthcare agency _____ Ins. Policy # _____

Medical Information

Any known allergies (including drug allergies or severe allergies to animals, foods or other substances)?
If yes, describe _____

Date of last tetanus shot _____ Medication student is presently taking _____
How often _____
Reason _____

List any physical factors that might affect student's activity or would be necessary for a physician to know when caring for your student/child

Parental Permission

I give my student/child full permission to participate in this trip. _____
parent/guardian signature Date

If an emergency arises, it might be necessary to seek care for your student before staff can contact you. Such care can be provided only if you sign the authorization below. Either the authorization or a statement of the reason for not allowing it should accompany this health form.

In case of minor illness or injury, I, _____, of _____,
parent or guardian student/child
give my permission for the supervisor of my student/child to administer necessary treatment and/or first aid. In case of an emergency, I hereby authorize the official representative of my student's/child's school or the person in charge of the program to permit a physician/hospital to administer emergency or surgical care, and I further authorize any licensed physician, medical facility or trained emergency technician to administer emergency or surgical care.

Signature of parent or guardian Date