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: _C C_   **Trip Dates:** _Sept. 10-11, 2021_   **Destination:** _Sioux Falls SD_
Lodging: _Staybridge Suites_   **Contact Number:** _605-361-2298_
Coaches/Advisor Contact Number _Jane_   _612-889-2456_
Jeff   _952-217-3731_

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.

_____   _____
                                     Date

_____
Signature of parent or guardian