THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA
PUPIL SUPPORT SERVICES
1960 LANDINGS BOULEVARD, SARASOTA FL 34231-3331
TELEPHONE: (941) 927-9000

EMERGENCY MEDICAL/TREATMENT FIELD TRIP CONSENT FORM

Date: _____

Name of Student: _____ Date of Birth: _____
Last First Middle

Home Address: _____
Street City Zip Code

Parent/Guardian: _____ Relationship: _____

Address of above (if different): _____
Street City Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please list a person other than the parent or guardian who could be contacted in case of an emergency below:

Emergency Contact:_____ Phone #: _____

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

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

_____

Does the above student take any daily medication? _____ Yes _____ No

If Yes, please compete the medication treatment authorization form (if not previously on file in the school Health Room) and lease list the medication 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 Signature: _____ Date: _____

Distribution: White - Office Yellow - Teacher