

# Travel Authorization & Medical Treatment of Minors

Name of Minor \_\_\_\_\_

Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_

Age: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

In an emergency, and unable to reach parent/guardian, notify:

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Health Concerns/Allergies: \_\_\_\_\_

Food/Dietary Restrictions: \_\_\_\_\_

Are all vaccinations current:      YES              NO

If you are requesting staff members to administer medication, prescription or over-the-counter, please visit Mayfield Website>Families>Health Services and complete appropriate forms. These forms may be faxed or brought to the school. All medications, prescription or OTC, require a completed form for Mayfield to administer. Mayfield Middle School will provide acetaminophen, ibuprofen, Dramamine, and TUMS for pain, fever, motion sickness, and stomach upset.

Please sign the consent below if you would like to have these medications available for your child.

Acetaminophen     Ibuprofen     Dramamine     TUMS     All of the above

I give my consent to authorize school personnel to administer these medications to my child while on an overnight school trip. I understand that Mayfield Middle Schools will supply these medications. I request authorized school personnel to follow the package instructions as directed for my child.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

**Authorization for Emergency Treatment** I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for Mayfield City Schools, to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize Mayfield City Schools, to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for an X-ray, anesthetic, blood transfusion medication, or other medical diagnosis, treatment, or hospital care deem advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice. I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of Mayfield City Schools in the exercise of Mayfield's best judgment upon the advice of any such medical or emergency personnel.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_