Marshall School

Overnight Field Trip Health Form

Camp Menogyn *- Return form to school*
no later than ***August 25, 2021*** *or* ***ASAP upon receiving****.*

I understand that my child has an opportunity to participate in this field trip. This trip will be under the direct supervision of a faculty member(s) of Marshall School and my child will be transported in a contracted or designated vehicle (chartered service for certain trip/outings).

a) I request that my son/daughter be allowed to attend this field trip;
b) The undersigned agrees to release, discharge, defend, hold harmless and indemnify Marshall School, its agents, employees, officers, trustees, representatives, insurers and others acting on Marshall School's behalf, of and from all claims, demands, causes of action and legal liabilities for injuries or death to my son/daughter due to their ordinary negligence; the undersigned further agrees, except in the event of gross negligence or willful and wanton misconduct on part of Marshall School, not to bring any claims, demands, legal actions and causes of action for any economic and non-economic losses due to bodily injury, death or property damage sustained by my son/daughter. (signature required at bottom of page 2)

Student Information:

Student's Name _____ Birth Date _____

Address _____ Phone _____

Emergency Phone Numbers:

Parent or Guardian _____ List ALL Phone #'s _____

Parent or Guardian _____ List ALL Phone #'s _____

Emergency Contacts (if you are not reachable):

Name _____ List ALL Phone #'s _____

Relationship _____

Student's Physician _____ Phone _____

Student's Dentist _____ Phone _____

Parent(s)/Guardian will assume the full cost of any medical or hospital expenses incurred. Medical payment coverage and reimbursement for said child is as follows:

Health insurance or medical relief coverage by _____

Phone Number _____

Policy Number _____

Important Health Information:

Do you know of any health factors that make it inadvisable for your child to participate in physical activities during this field trip? (If you're unsure of the range of physical activities that may occur, please consult your child's teacher).
YES _____ NO _____ If yes, please explain _____

_____

Has your child had any serious illnesses, operation, hospitalizations, or serious accidents during the past year?
YES _____ NO _____ If yes, please explain _____

_____

HEALTH FORM **Student name:** _____ **DOB:** _____

Does your child have any allergies or health concerns? YES _____ NO _____
If yes, please explain _____

_____

Is your child receiving any medication either at home and/or at school? YES _____ NO _____
If yes, name of the medication(s) _____

Reason for the medication(s) _____

Will you be sending any medication(s) with your child on this field trip? YES **(List Below)** NO _____

AUTHORIZATION TO ADMINISTER MEDICATION: PLEASE READ: All prescription or over-the-counter medications - REQUIRE an MD SIGNATURE.
List **ALL** medications below. Your student must agree not to share their medication with any other student**.**

Name of Medication(s)	**Dose**	**Times to be given**

Side effects from above medication(s): _____

The following applies to asthma inhalers only:
* It is acceptable for the student to carry asthma inhaler medication on his/her person. YES _____ NO _____

* It is acceptable for the student to administer his/her own asthma inhaler medication. YES _____ NO _____

I hereby authorize _____ to release information to
(Health Care Clinic Name)
Marshall School 1215 Rice Lake Road Duluth, MN 55811

**** PHYSICIAN'S SIGNATURE** _____ Date _____

Physician NAME (Print) _____ Phone _____

- AUTHORIZATION FOR MEDICAL TREATMENT – TO BE COMPLETED AND SIGNED BY ALL PARENTS -

We the undersigned parent/guardian of above named student grant and assign staff members and volunteers of Marshall School the authority and consent to sign medical emergency release documents both for doctors and hospitals on behalf of our child, and grant and assign them permission and consent for emergency medical treatment, operation, administration of anesthesia, blood transfusion, or urgent medical treatment of any illness or injury that any qualified medical practitioner may deem necessary for our child's welfare in the event parents cannot be contacted.

It is further understood that staff members will notify the parent/guardian of any medical treatment as soon as possible.

I request & authorize designated school personnel to give the above prescription medication. I authorize my student to self-administer any over-the-counter, non-aspirin pain medication or inhaler medication that I send with my student.
I release school personnel from any liability should reactions result from these medications.
I give permission for the school Nurse to contact my health care provider regarding this medication, if questions or concerns.

_____ _____
Parent/Guardian Signature Date