I hereby give permission for the CFHS Band Staff and/or Parent Chaperone(s) to contact my student directly by phone/text with any information or instructions with regard to the medication(s) that my student needs to take during the dates described below.

Student's Name: _____

Student's Section: _____

Student's Phone number: (____) _____

Date(s) of Event: _____

Parent/Guardian Name:_____

Parent/Guardian Signature: _____

Parent/Guardian Phone Number: _____

MEDICAL CONSENT AND RELEASE FORM
(FOR MEDICAL CENTER PERSONNEL)

Student's Name _____

In the event of illness or injury, I agree to any emergency treatment deemed necessary by the medical personnel designated by the school authorities. Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, X-ray examinations and immunizations for the above named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given.

Signature_____Date_____
(parent or guardian)

IF WE NEED TO CONTACT YOU:

Parent/Guardian 1:_____Parent/Guardian 2: _____

Home Phone:_____Home Phone: _____

Cell Phone:_____Cell Phone: _____

Work Phone:_____Work Phone: _____

Name and phone number of friend or relative who could locate you in an emergency:

Name_____Phone _____

Student's doctor_____Phone _____

The student named above has medical insurance. Yes_____No _____

Insurance Carrier_____Policy No. _____

MEDICAL INFORMATION:	YES	NO	IF YES, EXPLAIN
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Daily Medication	_____	_____	_____
Diabetes	_____	_____	_____
Other health concerns	_____	_____	_____

Rachel Howard, RN, BSN, MSN
District Health Coordinator
Catalina Foothills
School District

ENVISION 21
DEEP LEARNING
CATALINA FOOTHILLS SCHOOL DISTRICT

Phone: (520) 209-8081
rhoward@cfsd16.org
2001 E. River Rd.
Tucson, AZ 85718

CATALINA FOOTHILLS SCHOOL DISTRICT
FIELD TRIP MEDICATION CONSENT AND RECORD FORM

Student Name:	DOB:	Grade:	School:

- All medications must be provided in the original prescription or over-the-counter (OTC) container/package labeled with the student's name. **Any medication that is not in the original packaging will not be given. Any medication that is not listed on this form will not be given.** Please provide only the amount needed for the duration of the trip. An updated form will be required for each trip, as information may change.
- Tylenol, ibuprofen and TUMS and cough drops will be stocked for each trip. If your child may have these please check the box below and return this form.

STOCK MEDICATIONS:

- ☐ **TYLENOL**
- ☐ **TUMS**
- ☐ **IBUPROFEN**
- ☐ **COUGH DROPS**

PERMISSION TO SELF-CARRY

_____ I acknowledge that my student may carry and administer their own emergency medication (i.e. inhaler, EpiPen, glucagon).

1. Medication name:_____
2. Medication name:_____

Parent/Guardian signature:_____ Date:_____

District staff signature:_____ Date:_____

NOTARIZATION REQUIRED FOR OUT-OF-STATE AND INTERNATIONAL TRIPS

Sworn and subscribed to before me_____ of the County

of_____, State of Arizona, this _____ day of

_____, 20____.

_____

Signature of Notary
My commission expires:_____

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SECTION 1: NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION (other than the stock meds listed on previous page)

***All OTC medications must be in the original packaging and placed in labeled Ziplock with student's name**. Please provide clear instructions below.

1.

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:_____
Amount returned:_____ Parent initial:_____

DATE	TIME	INITIAL	DATE	TIME	INITIAL

2.

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:_____
Amount returned:_____ Parent initial:_____

DATE	TIME	INITIAL	DATE	TIME	INITIAL

3.

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:_____
Amount returned:_____ Parent initial:_____

DATE	TIME	INITIAL	DATE	TIME	INITIAL

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SECTION 2: PRESCRIPTION MEDICATION

***All prescription medications must be in the original container with the appropriate pharmacy label attached. The pharmacy label instructions should match the instructions below.**

1.

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:_____
Amount returned:_____ Parent initial:_____

DATE	TIME	INITIAL	DATE	TIME	INITIAL

2.

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:_____
Amount returned:_____ Parent initial:_____

DATE	TIME	INITIAL	DATE	TIME	INITIAL

3.

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:_____
Amount returned:_____ Parent initial:_____

DATE	TIME	INITIAL	DATE	TIME	INITIAL

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EXTRA MEDICATION LOG

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:______
Amount returned:______ Parent initial:________

DATE	TIME	INITIAL	DATE	TIME	INITIAL

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:______
Amount returned:______ Parent initial:________

DATE	TIME	INITIAL	DATE	TIME	INITIAL

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:______
Amount returned:______ Parent initial:________

DATE	TIME	INITIAL	DATE	TIME	INITIAL

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NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:______
Amount returned:______ Parent initial:________

DATE	TIME	INITIAL	DATE	TIME	INITIAL

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:______
Amount returned:______ Parent initial:________

DATE	TIME	INITIAL	DATE	TIME	INITIAL

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:______
Amount returned:______ Parent initial:________

DATE	TIME	INITIAL	DATE	TIME	INITIAL

NAME	DOSE	HOW OFTEN/TIME	REASON

Amount received:______
Amount returned:______ Parent initial:________

DATE	TIME	INITIAL	DATE	TIME	INITIAL