Har-Bur Middle School

Serving Towns of Harwinton and Burlington

WASHINGTON, D.C. TRIP

Medical Release/Treatment Form

Student Name: _____
(last) (first) (middle)

Address: _____
(street) (town) (state) (zip code)

Date of Birth: _____ Student's Social Security #: _____

Parent/Guardian (Father) Name: _____
Address: _____
Home: _____

Parent/Guardian (Mother) Name: _____
Address (if different): _____

Father's Work Phone: _____ Cell Phone: _____

Mother's Work Phone: _____ Cell Phone: _____

Alternate contact in case of emergency: _____
Relationship to child: _____
Contact information (phone number): _____

Name and Address of Family Physician: Dr. _____
(first) (last)

_____
(street) (town) (state) (zip code)

Office Phone:_____

Any drug, food or allergy condition, which may require special treatment, should be listed below. Please explain allergy and necessary medications, or treatment(s).

_____
_____
_____
_____

(over)

Any physical limitations should be listed below.

_____
_____
_____
_____

Parent/Guardian must authorize which non-prescription medication, approved by our school medical advisory/physician, listed below may be given by checking yes or no next to the name of the medication. If you do not complete the following section, **NO medication can/will be given.

Non-Prescription medication	Oral Dose	Reason Medication is to be given	YES	NO
Acetaminophen – 325 mgm tabs	1-2 tablets every 4 hours as needed	Pain/elevated fever		
Tums or Rolaids	1-2 tablets every 4 hours	Indigestion		

These are the only medications covered under this permission form. Prescription or other over the counter medications require a separate form signed by the student's physician. Please DO NOT write in any other medication. All other medications require the "Prescription/Over the Counter Medication Form" to be filled out and signed by student's physician and the parent/guardian, which is available through the nurse's office.

If your child takes prescriptions and will need them on the trip we must have a doctor's prescription for each drug.

Please supply us with your child's medical coverage information.

Name of Company: _____

Name of Insured: _____

Policy Type and Number: _____

Required: Please attach a copy of your insurance card (front/back)