MEDICAL HEALTH INFORMATION
MEDICAL AUTHORIZATION

Student Name _____

I hereby represent to Primero RE-2 School District that the student is in good physical health and the trip does not pose a hospital hazard to the student.

I hereby grant permission and give my consent for the above named student to:

1. Be treated by any physician, physician assistant, or nurse practitioner as may be deemed by Primero School District, its agents, servants, or employees during a trip.
2. Be administered medication and/or emergency first aid as may be necessary or appropriate.
3. Receive treatment in hospitals, medical offices, clinics, or elsewhere in the event of an accident or illness.

To assist in the medical care or treatment the medication information herewith supplied on the attached Health Information Form is true and accurate. I will hold the school and its agents, servants and employees harmless and indemnify them from any claim, cause of action or demand arising out of any form of (or lack of) medical or emergency treatment rendered to the student.

The student, by his/her signature hereto fully agrees and consents to the following.

THE CONDITIONS AND STATEMENTS ON THE REVERSE SIDE ARE INTERGRAL PART OF THIS AGREEMENT.

Student signature _____ Date _____

Parent/Guardian _____ Date _____

HEALTH INFORMATION FORM

Student Name _____ Parent Name _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

EMERGENCY CONTACT PERSON

Name _____ Phone _____

Family Physician _____ Phone _____

Health Insurance Company _____ Policy Number _____

- List any significant health problems the student may have _____
- List any drug allergies the student may have _____
- List ALL medication the student is taking at this time _____