PLEASANTON UNIFIED SCHOOL DISTRICT
STUDENT FIELD TRIP AUTHORIZATION
EMERGENCY MEDICAL INFORMATION

Name of Child: _____ Date: _____ Student ID#: _____

Name of Parent/Guardian: _____ Home Phone: _____

Work Phone #1: _____ Cell Phone: _____

Name of Physician: _____ Physician Phone: _____

Name of Dentist: _____ Dentist Phone: _____

Name of Medical Insurance Company: _____

Group/Coverage Number: _____

Allergic to the following: _____

Taking the following medication(s) at home: _____
List medications your student needs during the field trip:

1. _____

☐ Already in Health Office ☐ Parent will provide medication with Medication Consent Form (required for prescription and over the counter medications)

2. _____

☐ Already in Health Office ☐ Parent will provide medication with Medication Consent Form (required for prescription and over the counter medications)

3. _____

☐ Already in Health Office ☐ Parent will provide medication with Medication Consent Form (required for prescription and over the counter medications)

Special Instructions:

_____

_____

I hereby give my consent to the Pleasanton Unified School District, to whose care my child has been entrusted, the authorization for any emergency medical treatment, including any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care needed to be rendered on the advice of any physician, surgeon, medical practitioner, or under the provisions of the Dental Practice Act.

_____ _____
Signature of Parent/Guardian Date

_____ received medications from parent _____ returned medications to parent
initial & date initial & date