CARROLLTON-FARMERS BRANCH INDEPENDENT SCHOOL DISTRICT
MEDICAL RELEASE FORM FOR SCHOOL SPONSORED STUDENT TRAVEL

(This form must be taken on the trip by the event sponsor.)

I, _____, the parent/guardian of
(Print Parent/Guardian's Name)

_____ do hereby give my permission to the
(Print Student's Name)

Carrollton - Farmers Branch Independent School District during the_____
(Print Activity / Event Name)

to secure medical attention for my child in the event of accident or illness while under his/her supervision. I understand that the adult sponsor will attempt to contact me before releasing my child to the care of a doctor or hospital.

Should my child need medical attention, and I cannot be contacted, neither the sponsor, the Carrollton-Farmers Branch Independent School District, or its representatives are to be held responsible for any occurrence which might transpire during the rendering of medical services to my child by a doctor or hospital staff to whom my child may have been released.

It is further understood that the case of accident or illness which requires the services of a doctor or hospital, that I will assume the payment of all expenses incurred in securing the services of the doctor or hospital.

I further stipulate, that the reverse side of this document contains confidential information which I have supplied regarding my child's medical status, and that the information is correct. This information is to be shared with an attending physician and/or hospital staff member only in the case of emergency.

STUDENT MEDICAL INFORMATION

Student Last Name_____ First _____ M. I. ____

Parent/Guardian Name _____

Home Phone _____ Work Phone _____ Cell_____

Home Address (Street)._____ City_____ _____ Zip Code _____

Student's Date of Birth _____ Student's Social Security Number_____-_____-_____

In the event of an emergency and you cannot be reached, please list two other persons we should call in an attempt to find you.

Name _____ Relation_____

Home Phone _____Work Phone _____ Cell_____

Name _____ Relation_____

Home Phone _____Work Phone _____ Cell_____

In the event of an emergency, and I cannot be reached, I hereby authorize the school district's designated representative to take whatever action is deemed necessary and appropriate, including giving consent for medical treatment for the above named child.
(Section 35.01 Texas Family Code)

PLEASE COMPLETE BACK OF FORM!

Is your child allergic to any medication, food, insects, or plants? YES_____ NO_____
If "YES," please list any allergies your child has to medication, food, insects, plants, etc.

_____

_____

Please give any information about your child's physical or medical conditions that you feel would be important in the case of an emergency.

_____

_____

If medication is to be administered during the trip, please fill out the release form as specified below.
I hereby give permission for _____to be given the medications only as prescribed and listed below.
(Student's Name)

Name of medication: _____ Dosage: _____ Time(s): _____

Name of medication: _____ Dosage: _____ Time(s): _____

Name of medication:_____ Dosage: _____Time(s): _____
I understand that the medication must be in the original container and properly labeled (including the student's name) for the medication to be administered.

Signature of parent/guardian listed above:

_____ Date: _____

Insurance Company _____ Policy Number _____

Phone Number _____