

**Greeneville City Schools
School Health Services**

**OFF CAMPUS ACTIVITIES
CONSENT FOR EMERGENCY MEDICAL TREATMENT**

To be completed by parent/guardian with custodial rights.

Student Full Name: _____

Date of Birth: ____/____/____ **Sex:** ____ M ____ F **School:** _____

Parent/Guardian Name: _____

Home Address: _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Parent/Guardian Name: _____

Home Address: _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Alternate Emergency Contact (other than parent/guardian)

Name: _____ **Relationship:** _____

Address: _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Student's Primary Doctor: _____

Office Address: _____ **Office Phone:** _____

Student's Insurance: _____

Policy #: _____ **Group #:** _____

Name of Primary person insured: _____

(PLEASE SEND A COPY, FRONT AND BACK, OF THE INSURANCE CARD)

Parental / Guardian Consent for Medical Treatment

I hereby give consent for the above named student to be given medical treatment in the event of an injury or illness while under the supervision of Greeneville City Schools' personnel during off campus activities. I also understand that it may be necessary to transport my child to the nearest medical facility depending on the child's illness or injury. My signature indicates that I am giving consent to medical treatment in the event of an illness or injury and that consent is granted for any off campus activity for the entire school year.

Signature of Custodial Parent/Guardian

Date

Administration of Medications During Off Campus Activities for Greeneville City School Students

Student Name: _____ Date of Birth: _____

Grade _____ Teacher _____ School _____

Name of off campus activity: _____ Date(s) covered by this form: _____

ALLERGIES (PLEASE LIST) include bee stings, food allergies, and MEDICATION allergies. If none, please indicate.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

List all medication(s) (both prescription and non-prescription) you will be providing to the school prior to departure that should be administered to your child while he/she is participating in the off campus activity. Listing of the medication and your signature at the bottom of this form gives permission for Greeneville City School personnel to administer the medication to your child while on the off campus activity. All medication sent to the school must be in the original container. Medications must be submitted at least one week before departure to the school nurse.

Name of Medication	Strength	Dosage	Times to be taken	Purpose

Special instructions regarding medications and/or allergies:

Date of Last Tetanus Shot _____

List below any additional health information that the staff should be aware of:

School personnel will be carrying the medication listed below. To give permission for your student to be treated with these medications while on this trip you must check the medications that may be given—**IF YOU HAVE NOT GIVEN US PERMISSION TO ADMINISTER THE MEDICATIONS BY CHECKING THE APPROPRIATE LINES YOUR STUDENT WILL NOT RECEIVE ANY OF THESE MEDICATIONS WHILE ON THIS TRIP.** Medications will be dosed according to manufacturers' recommendations.

(This does not grant permission for these items to be given at any other time during the school year.)

- | | | |
|--|---|---|
| <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Benadryl (liquid/caps) | <input type="checkbox"/> Contact lens cleaner |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Anti-itch spray | <input type="checkbox"/> Cough drops |
| <input type="checkbox"/> Antibiotic cream/oint. (Non-prescription) | <input type="checkbox"/> Chewable antacids | <input type="checkbox"/> Imodium |
| <input type="checkbox"/> Hydrocortisone cream 1% | <input type="checkbox"/> Dramamine | <input type="checkbox"/> Emetrol (nausea) |

Please list any medications that your child should not have _____. Additional permission forms are available at school or online at www.gcschools.net under District Forms/Coordinated School Health/Off Campus Activities.

My child _____ may _____ may not self-administer their medications.

The undersigned parent/guardian hereby agrees to give personnel of Greeneville City Schools permission to administer the above listed medication(s) to my child. I release the Greeneville City School System and its personnel from any legal claim they now have or may thereafter have arising out of the assistance with self-administration of or failure to administer medication to the student. I will assume full responsibility for any side effects and complications that my child may have as a result of medications.

Signature of Custodial parent/guardian

Date