DEXTER COMMUNITY SCHOOLS
7714 Ann Arbor Street, Dexter, Michigan 48130
www.dexterschools.org
(734) 424-4100

CONFIDENTIAL

Student Name_____

STUDENT TRAVEL MEDICAL RELEASE

This form grants temporary authorization to an administrator of Dexter Community Schools or an adult chaperone designated by Dexter Community Schools (hereafter "Designated Adult") to provide and arrange for medical care for a student in the event of an emergency, where the student is a minor and not accompanied by either parent or legal guardian, and it may not be feasible or practical to contact them. This form should be carried by the Designated Adult.

Event _____ Event Dates _____ through _____

Minor
Student Legal Name _____ Birth Date _____
Home Address _____
Gender: Male/Female

Information for Medical Treatment
Physician's Name _____ Phone _____
Physician's Address _____

Medical Insurer/Health Plan _____ Phone _____
Policy Holder _____
Policy Numbers: Contract # _____ Group # _____

Allergies to Medications: Yes/No If yes, please list allergy and reaction:
_____
Allergies (Others): Yes/No If yes, please list allergy and reaction:
_____
Epinephrine auto injector prescribed: Yes/No If yes, please attach physician's Allergy Action Plan
Please list ALL conditions for which the child is currently receiving treatment:
_____
Please list any other significant medical information:
_____
Please list all medications currently being taken on a daily schedule or as needed:
Medication Name Dosage Schedule Reason Taken
_____
_____

I give permission for the following over-the-counter (OTC) medications to be administered to my child, if needed. Please check only ONE of the three options:
_____ *Option 1.* ALL. It is OK to administer any of the OTC medications listed to my child, if the need arises.
_____ *Option 2*. NONE. Do not administer any OTC medication to my child.
_____ *Option 3*. SPECIFIC MEDICATIONS: It is OK to administer ONLY the OTC medications checked, if the need arises. Please draw a line through any OTC medication you do not give consent.

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_____ Ibuprofen (e.g., Motrin). Dose: 1-2 tablets (200 mg tablets) every 6 hours as needed
_____ Acetaminophen (e.g., Tylenol). Dose: 1-2 regular strength tablets (325 mg tablets) every 4 hours as needed (Either of above 2 medications for headaches, cramps, toothaches, fever etc.)
_____ Diphenhydramine (Benadryl). Dose: 1-2 tablets (25 mg tablets) every 6 hours as needed for itching or more severe allergic reactions
_____ Loperamide (Imodium). Dose: 2 caplets (2 mg tablets) at onset of diarrhea, 1 (2 mg) with each subsequent loose stool (not to exceed 4 caplets in 24 hours)
_____ Tums. Dose: Chew 1-2 tablets every 3-4 hours as needed for heartburn
_____ Pepto-Bismol. Dose: Chew 1-2 tablets every 3-4 hours as needed for upset stomach
_____ Meclizine hydrochloride (Dramamine II). Dose: 1-2 tablets (25 mg tablets) once daily as needed for motion sickness. Maximum: 2 tablets in 24 hours.
_____ Cough drops & throat lozenges
_____ Sunscreen to prevent sunburn
_____ Medicated talcum powder (e.g., Gold Bond) for irritated skin, friction rub from walking.
_____ Antibiotic ointment (e.g., Neosporin) for cuts, grazes, etc.
_____ 100% Aloe Vera gel to treat sunburn

Parent/Legal Guardian
Parent/Legal Guardian (primary contact)
Name _____ Phone _____
Address _____

Parent/Legal Guardian (alternative contact)
Name _____ Phone _____
Address _____

Authorization and Consent of Parent(s) or Legal Guardian(s)
Signed this _____ day of _____, 20_____, I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for an administrator of Dexter Community Schools or an adult chaperone designated by Dexter Community Schools to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon professional emergency personnel to attend, transport, and treat the Minor and to issue consent for any X-ray, anesthetic, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the area in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment and/or upon the advice of medical or emergency personnel.

A photocopy or faxed copy of this document can be relied upon as though it were original.

Parent/Legal Guardian Signature _____
Printed Name _____

Witness Signature _____
Printed Name _____ Phone _____