Berlin Area School District
Berlin, Wisconsin
920-361-2004
Berlin Middle School Trip Medical Form

Acknowledgement of Medical Information and Emergency Treatment Consent
-Please Print using Black Ink-

Student's Full Name_____ Grade_____

Date of Birth _____ Male____ Female____

Address_____
Street **City** **Zip**

Parent/Guardian_____ Phone #1 _____ Phone # 2_____

Parent/Guardian_____ Phone#1 _____ Phone # 2_____

Other Responsible Party_____ Phone#1 _____ Phone # 2_____

Family Physician_____ Phone _____

Health History

Please list any medical problems such as diabetes, heart problems, asthma, seizures, major or recent operations, emotional problems (hysteria, hyperventilation, etc.)_____

Is he/she currently under medical care? _____ Reason_____

Current medications **(Include name of drug, dose and times to be taken**) _____

_____

Bee Allergy: yes____ no____ Treatment: _____

Drug Allergies: _____ Food Allergies: _____Treatment:_____

Date of Last Tetanus Injection (**recommended at least every 10 years**): _____

Medications*: My son/daughter has permission to take the following over-the-counter medications and use as directed on the label of the medication. ***Parents must supply student's medications***:

Ibuprofen (Motrin, Advil) -- yes_____ no_____ Acetaminophen (Tylenol) -- yes_____ no_____
Antacids (Tums,Rolaids) -- yes_____ no_____ Cough or Throat Lozenges -- yes_____ no_____
Pseudoephedrine (Sudafed) -- yes____ no____ Diphenhydramine (Benadryl) -- yes____ no_____
Other_____

All medications must be turned in to the trip advisor. All prescription medications must be in a correctly labeled pharmaceutical bottle and the appropriate permission form must accompany it.

My child has permission to swim if there is an opportunity: yes_____ no_____
Swimming ability is: excellent_____ good_____ fair_____ poor_____

Insurance Company_____ Group Number_____
Individual Number_____

I (we) give permission that if emergency medical treatment is required and parents cannot be reached immediately, the student may be brought to the nearest emergency room or medical clinic or an ambulance may be called if deemed necessary.

Trip/Location: _____ Purpose: _____ Dates_____

_____ _____

Father/Guardian Signature **Date** **Mother/Guardian Signature** **Date**

***Photostatic copies of this medical authorization shall be as effective as the signed original** *Revised January 2012*