



**Detroit Public Schools Community District**  
**Student Field Trip Emergency Medical Authorization Consent Form**

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Description of Field Trip/Activity: \_\_\_\_\_

Destination: \_\_\_\_\_

Field Trip Travel Date(s) Departure: \_\_\_\_\_ Return: \_\_\_\_\_

**General Information:**

Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Parents/Guardian Name: \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_ Cell/Emergency Phone: (\_\_\_\_) \_\_\_\_\_

**Medical History:**

Does student have diabetes, epilepsy, allergies or other health problems? \_\_\_\_ No \_\_\_\_ Yes

If yes, please specify \_\_\_\_\_

Is student currently taking any medication (include antihistamines, aspirin, tranquilizers, insulin)? \_\_\_\_ No

\_\_\_\_ Yes \_\_\_\_ If yes, please specify \_\_\_\_\_

Is student currently under medical treatment? \_\_\_\_ No \_\_\_\_ Yes

If yes, please specify \_\_\_\_\_

**Physician Name:** \_\_\_\_\_

Physician Office Phone: (\_\_\_\_) \_\_\_\_\_ Physician Emergency/Cell Phone: (\_\_\_\_) \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Parent or Legal Guardian Consent:**

I (we) hereby give permission for the above-named student to be treated by a physician or licensed nurse at a hospital or on the scene in the event of a medical emergency. I (we) understand that the director, staff, chaperones, escort and/or medical personnel will be acting in the best interest of my (our) child, and I (we) will not hold them responsible for any decisions they make. I am signing this agreement voluntarily with full knowledge of its significance and intend by my signature to be a complete and unconditional release of all liability to the extent permitted by law.

**Parent/Guardian Name (Print)** \_\_\_\_\_

**Parent/Guardian Signature (s)** \_\_\_\_\_

**Today's Date** \_\_\_\_\_