

Medical Release Form

ARIZONA CULTURAL ACADEMY



Participant's Name -----

Last Name

First Name

Middle Initial

Name of Parent/ guardian -----Phone number -----

Field Trip Date(s) -----to-----

Destination ----- Alternate Destination, if applicable -----

Is field trip: ___ Overnight In-State Trip ___ out-of State Trip

Mode of Transportation -----Cost to Student/participant \$ -----

Health and Medical History

“Due to limited resources the Umrah Committee cannot accept applicants who need special medical attention e.g. those who have serious medical conditions”.

List Student's / Participant's Allergies: -----

List Student's / Participant's Health Conditions: -----

List all medications (prescription and over the counter) that student/participant takes. Include as-needed and emergency medications.

*Medication Name (On label or box)	Dose Ordered	Time(s) Ordered	**Written Authorization to Carry and Self-Administer?

(Add additional information on different paper if necessary)

*All medications must be in the original container. Medications not authorized for students to carry and administer must be given to the staff member designated to provide health services or the supervising teacher for proper storage.

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** For Student/Participant to carry and self-administer. Prescription medicines must have written authorization of prescribing healthcare provider and over the counter medications must have written approval of parent/guardian.

Student's/Participant Healthcare Provider: -----

Telephone: -----

Health Insurance

Student's /Participant Health Insurance Carrier Name: -----

Carrier address -----

Name insured ----- Policy ID # -----

Health Plan -----Group No. -----

(A copy of the insurance card (both sides) showing student's /participant name on the card is preferred)

I hereby give permission for my child/myself to participate in the above-mentioned school-related student trip(s). All health information provided by me to the school for this field trip is correct and accurate to the best of my knowledge. I authorize trained school personnel to assist my child/I with the medication as my child's healthcare provider/I or I have directed if needed. In addition, in the event of accident or sudden illness while on the school-related student trip. I authorize school personnel to have my child/I transported by ACA trip leaders to the nearest hospital and authorize treatment as may be deemed necessary in an emergency for the health of said child/I. In the event physician(s), parent(s), or other persons designated by the parent cannot be contacted, school personnel are hereby authorized to take whatever action is deemed necessary in their judgment for the health of said child/I.

Parent/Guardian's /Self Signature

Date