LIVERMORE VALLEY JOINT UNIFIED SCHOOL DISTRICT
Student Field Trip Authorization
Emergency Medical Information

Student Name: ___________________________________ Date: ____________ Teacher: ___________________

Parent/Guardian: ________________________________ Home Phone: _________________________________

Cell Phone: _______________________

Alt Phone: _____________________________________

Physician: ______________________________

Physician Phone: ________________________________

Dentist: ________________________________

Dentist Phone: __________________________________

Medical Insurance: ____

Health Concerns/ Allergies: ____

Medications taken at home: ____

Medications your student may need on the field trip:

1. ____

   ☐ In Health Office ☐ Parent will provide medication and Medication Consent Form (required for prescription and over the counter medications)

2. ____

   ☐ In Health Office ☐ Parent will provide medication and Medication Consent Form (required for prescription and over the counter medications)

3. ____

   ☐ In Health Office ☐ Parent will provide medication and Medication Consent Form (required for prescription and over the counter medications)

Special Instructions: ____

I hereby give consent to Livermore Valley Joint Unified School District, to whom my child has been entrusted, to authorize any emergency medical treatment, including x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care needed to be rendered on the advice of any physician, surgeon, medical practitioner or under the provision of the Dental Practice Act.

Signature of Parent/ Guardian: _______________________________________Date: ____________

Received medication from Parent/Health Office ______________ Initial & Date

Returned medication to Parent/Health Office ______________ Initial & Date