

**Littleton
Public
Schools
Exhibit**

Policy Code **JJH-E-3**
Policy Name **Student Travel**
May 13, 2004

EMERGENCY MEDICAL AUTHORIZATION

I/we, the undersigned parents/guardians of _____ (hereinafter "my Student"), hereby represent to Littleton Public Schools (hereinafter the "District") that my Student is in good physical health and the Trip does not pose a health hazard to my Student.

I/we hereby grant permission and give my/our consent for my Student to (1) be treated by any qualified nurse, physician, or surgeon as may be deemed necessary by the District, its agents, servants, or employees during the Trip; (2) be administered medication and/or emergency first aid care as may be necessary or appropriate; and (3) receive treatment in hospitals, medical offices, clinics, or elsewhere in the event of accident or illness. To assist in that medical care or treatment, I/we represent that the medical information supplied on the Health Information Form below is true and accurate. I/we understand and agree that neither the District nor its agents, servants, or employees are responsible for obtaining, or for the result of any medical or emergency treatment rendered or supplied to my Student. I/we will hold the District and its agents, servants, and employees harmless and indemnify them from any claim, cause of action or demand arising out of any form of or the lack of medical or emergency treatment rendered to my Student. I/we further promise to reimburse the District, its agents, servants, or employees for any expenditures incurred for the benefit of my Student, including any such medical emergencies.

My Student, by his/her signature hereto, fully agrees and consents to the foregoing.

Signature of Student

Date

Signature(s) of Parent/Guardian

Date

HEALTH INFORMATION

Student name _____ Parent name _____

Address _____

Home phone _____ Parent work phone _____

Other contact number(s) _____

Emergency contact, if parent unavailable _____ Phone _____

Family physician _____ Phone _____

Health insurance provider _____ Policy number _____

Phone _____ (Attach front and back copy of health insurance card.)

Information of which sponsors should be aware:

1. Significant health problems of student .

2. Unusual reactions or allergies to drugs _____

3. Medications student currently on/will be taking while on trip _____

4. Special care needed while on trip _____

5. Special instructions to medical personnel if emergency care needed _____

6. Attach copy of current Health Care Action Plan if appropriate.

Plan is attached.

My student does not have a Health Care Action Plan.