

**Avon Grove School District**  
**Medical Consent Form**

Please type or print legibly.

STUDENT \_\_\_\_\_

STUDENT'S BIRTH DATE \_\_\_\_\_

MEDICAL INSURANCE CARRIER \_\_\_\_\_

INSURANCE POLICY NUMBER \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

NAME(S) OF  
PARENT(S)/GUARDIANS(S) \_\_\_\_\_

TELEPHONE NUMBERS WHERE PARENTS/GUARDIANS CAN BE REACHED:

HOME \_\_\_\_\_

WORK \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_

OFFICE ADDRESS \_\_\_\_\_

DOCTOR'S TELEPHONE NUMBER \_\_\_\_\_

EMERGENCY CONTACT IF PARENTS CANNOT BE REACHED:

NAME \_\_\_\_\_ TELEPHONE \_\_\_\_\_

DESCRIBE ANY HEALTH CONDITION OR ALLERGIES (FOOD, MEDICATION,  
BEE STING, ETC.) OF WHICH CHAPERONES SHOULD BE AWARE.

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\_\_\_\_\_

LIST ALL PRESCRIPTION MEDICATIONS THAT MAY OR WILL BE TAKEN BY STUDENT ON TRIP. NOTE: CHAPERONES WILL NOT DISPENSE ANY MEDICATIONS.

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LIST ALL OVER-THE-COUNTER MEDICATIONS THAT MAY OR WILL BE TAKEN BY STUDENT ON TRIP. NOTE: CHAPERONES WILL NOT DISPENSE ANY MEDICATIONS.

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Please make sure all necessary medication for a chronic or occasional problem is taken on the trip, and the trip chaperones know about the medication. This includes aspirin, Tylenol, Pepto Bismal, etc.

PERMISSION IS HEREBY GRANTED to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations, and immunizations for the above-named student. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If the physician is not able to communicate with me, the treatment necessary for the best interest of the above-named student may be given, provided the faculty representative from the Avon Grove School District is given a detailed statement of the proposed procedure and executes an informed consent. I/we do hereby release and absolve said representative and the Avon Grove School District from all liability resulting from granting said consent in good faith.

\_\_\_\_\_  
Parent/Guardian

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Subscribed and sworn to before me on the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
Notary Public

My commission expires \_\_\_\_\_