SIGN & RETURN

2025-2026 Medical Information/Travel Consent/Health Alerts

_____

(Student Name) (Date of Birth) (Grade)

Please check if your child has any of the following medical conditions:

Y / N Allergies - Please list:_____

Y / N Asthma **Y / N** Inhaler (If yes, please list the type and dosage): _____

*I certify that my child is competent to self-administer an inhaler and request that he/she carry an inhaler with him/her: **Y / N**

Y / N Diabetes **Y / N** Seizures/Seizure Disorders

Y / N My child has a documented hearing loss of thirty-five decibels or more, unaided unilaterally or bilaterally.

Y / N My child has additional health conditions. If yes, please list: _____

_____

Daily Medications:

Administered at home: _____

Administered at school:_____

If medication needs to be administered at school, proper paperwork will need to be filled out. Please contact your school office for the correct forms.
Medication must be provided in a bottle showing the name and telephone number of the pharmacy, student's name, physician's name and dosage of medication.

Please check the following medications that may be given to your child, if needed, by Alcester-Hudson school personnel:

___Tylenol ____ Ibuprofen ____ Please call before giving.

Primary Doctor's Name: _____ Primary Doctor's Phone #: _____

Travel/Activity Authorization: I give permission for my child _____who is in _____grade, to leave their school facility to attend school field trips that are part of our school activities and curriculum. The school district reserves the right to deny participation due to guidelines set in the student handbook.

Consent for Medical Treatment: I am the parent/guardian of _____who attend classes and participate in co-curricular activities at Alcester-Hudson School District. I hereby consent to any medical treatment that may be required while my child is under the supervision of an employee of the Alcester-Hudson School District during class or on a school- sponsored activity and hereby appoint said employee to act on behalf of my child in securing necessary medical treatment from any duly licensed medical provider. I agree to pay all expenses incurred in such an incident in accordance with School Policy EBBA: First Aid. The school is responsible for giving first aid or emergency treatment only in case of sudden illness or injury to a pupil or a member of the staff. Further-medical attention is the responsibility of the parent or guardian, or the person designated for emergencies, and in the case of a member of the staff, or the individual.

Parental Insurance Waiver: Alcester Hudson School District DOES NOT provide any type of health or accident insurance for injuries incurred by your child at school. We strongly encourage families to have accident coverage on their children, prior to participation in any school sponsored sports or activities. Since children are particularly susceptible to injuries, we encourage you to review your present health and accident insurance program to determine if your coverage is adequate.

HIPAA: The medical information identified on the form may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers, and other school personnel involved in the care of this student. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I do understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire on July 1, 2025.

By Signing below, I understand and agree with all the above statements.

_____

PARENT/GUARDIAN NAME (Please print) **PARENT/GUARDIAN SIGNATURE** **DATE**

PARENT/GUARDIAN EMERGENCY CONTACT: _____PHONE:_____

ADDITIONAL EMERGENCY CONTACT:_____PHONE:_____