**ONLY FILL OUT IF YOU MARKED "YES" ON FRONT PAGE

Medical Information Form

(Required for any student requiring medication or medical attention)

Student's Name: _____ **Date of Birth:** _____

Health Insurance Provider and Medical Plan #_____

Parent/Guardian's Name: _____ **Contact Number(s):** _____

Doctor's Name & Phone Number: _____

Emergency Contact Name & Phone Number: _____

List any ailments, disabilities or problems involving your child which may affect her/her participation.

Allergies (Food)_____ Allergies (Seasonal)_____

Asthma _____ Diabetes _____

Epilepsy _____ Other _____

Information sponsors should be aware of:

1. Unusual reactions or allergies to medication?_____
2. Special care needed while on activity?_____
3. Special instructions to medical personnel if emergency care is needed?_____
4. Significant health problems? _____

An employee trained to administer medication must accompany students needing prescribed medication during field study hours. All medications (prescription and over-the-counter) must have an Authorization to Assist in the Administration of Medication/Treatment form signed by both the parent/guardian and the physician ordering the medication, if not already on file in the school clinic. All medications must be received in the original container with the current Rx label including student's name, dosage, frequency of administration, physician's name and expiration date of the medication (the expiration date on the pharmacy label, not on the medication box, will be the expiration date). Over-the-counter medications must be in the original, unopened container. EXCEPTION: Students at the middle and high school level may carry a non-prescription, non-emergency medication on his/her person while in school with written permission from the parent/guardian. A copy of the signed permission form must accompany the stated medication at all times.

Name and purpose of medication: _____

How it will be given: _____ Time to be given:_____

Parent/guardian's signature: _____

IN CASE OF EMERGENCY: I hereby request the physician/emergency team selected by the activity supervisor provide treatment for my child named above.

Parent/guardian's signature: _____

Date: _____

St. Johns County School District
Parent Permission Form for Field Study Activities

School: Fruit Cove Middle School

I/We, the parents/guardians of the student named below, have been informed of the activities planned for the field study to: (If visiting multiple locations, list all.)

Universal Studios, 6000 Universal Studios Blvd, Orlando FL 32819 on May 15-16, 2026
(DATE)

Time to Leave: 1:00pm Return: 2:30am (Publix) Anticipated Number of Chaperones None

This field study includes a supervised water activity: Yes _____ No _____

Candies Coachworks, Inc via Charter Bus at a cost of $ $225.00
(Mode of Transportation)

We understand in times of national emergency or any other time when it is in the best interest of the health, safety and welfare of students and employees, the School Board may revoke its approval assuming no liability for reimbursement of costs or expenses incurred by the cancellation of any activity.

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 activity; (2) be administered medication and/or emergency first aid care as may be necessary or appropriate; and (3) receive treatment in hospitals, medical offices, 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 Medical Information Form is true and accurate. The District, its agents, servants, or employees are not responsible for acts or omissions of third parties as a result of securing medical care. I/We will hold the District and its agents, servants, or 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.

In the event that a student must return to school independently for reasons of health, accident, failure to conform to rules established by the teacher in charge, etc., we agree to accept full responsibility for and to pay for the cost of medical care, transportation and other incidental expenses. This permission slip also serves as a contract that the student and parent(s) understand and agree to the guidelines from each teacher as to making up missed assignments.

My student requires medication and/or non-emergent medical attention: YES _____ NO _____
**MUST ANSWER IF "YES" & FILL OUT THE MEDICAL FORM ON THE BACK OF THIS PAPER
If yes, you must complete the Medical Information Form ~~(obtained from the activity supervisor)~~ and provide an Authorization to Assist in the Administration of Medication/Treatment form signed by both the parent/guardian and the physician ordering the medication, if not already on file in the school clinic.

_____ _____
Signature of Parent/Guardian Date

_____ _____ _____
Cell Phone Work Phone Home Phone

Emergency contact if parent is unavailable _____ Phone _____
Family Physician _____ Phone _____
Health Insurance Provider _____ Policy# _____

Board Approved 8.12.14 Revised November 2022