Cain Middle School Band
RISD Medical Forms

ROCKWALL INDEPENDENT SCHOOL DISTRICT

Authorization to Secure Emergency Medical Treatment of Minor Student

Name of Minor	Grade	Date of Birth
Name of parent, guardian or conservator	Office Telephone Number	Home Telephone Number
Address of parent, guardian or conservator		
Name of other parent (or both if different from above) Mother:	Office Telephone Number	Home Telephone Number
Father:	Office Telephone Number	Home Telephone Number
Friend or relative who will probably know where to locate the parent in the event of temporary absence	Office Telephone Number	Home Telephone Number

This is to certify that I authorize the Superintendent of Rockwall Independent School District, Rockwall, Texas or a designated representative to secure any and all emergency medical care and treatment for _____ for acute illness suffered or injury sustained while at school or participating in school-related activities. This emergency treatment may be secured at a licensed hospital, clinic, or medical facility, or by a licensed physician or dentist with the following exceptions: _____

_____

Check One:

I ☐ do not have medical insurance ☐ do have medical insurance with _____ Insurance Company and I shall assume financial responsibility for any medical treatment of my child. I understand that the cost of services provided by ambulance, private physician, clinic, hospital or dentist remain the responsibility of the parent or guardian and shall not be assumed by the Superintendent, the designee, or the Rockwall Independent School District.

Copies of this authorization may be presented to the admissions office of a hospital or clinic or to a physician or dentist. Other distribution shall be only within the limitations of the Family Educational Rights and Privacy Act.

PLEASE COMPLETE REVERSE SIDE OF THIS DOCUMENT BEFORE SUBMITTING!

Date: _____ Signed: _____ (Parent/Guardian)

Day Trip – Secondary Campus
Medical/Emergency Information

TEACHER ___BAND___ **ID**_____

Student Name: _____ Date of Birth: _____ Weight: _____ lbs.

Emergency contacts during hours of this trip:

Name_____Relationship_____Phone_____Cell_____

Name_____Relationship_____Phone_____Cell_____

☐ I do not have medical insurance ☐ I do have medical insurance with _____ Insurance Company and I shall assume financial responsibility for any medical treatment of my child. I understand that the cost of services provided by ambulance, private physician, clinic, hospital or dentist remain the responsibility of the parent or guardian and shall not be assumed by the Superintendent, the designee, or the Rockwall Independent School District.

My child is allergic to: _____

Does your child have any allergies requiring an EpiPen*? YES ☐ NO ☐

Does your child have an inhaler prescribed for asthma*? YES ☐ NO ☐

*Students may carry their own inhaler or EpiPen if approved by their doctor (Ed. Code §38.015). Please see the school nurse ahead of the trip to complete the proper permission paperwork.

PRESCRIPTION MEDICATIONS

If your child will need any prescription medication during the trip, please complete below:

Medication	Dose and Route	Time (s) given	Reason for taking

All prescription medication must be in original labeled pharmacy container, with only enough doses required for the trip. **ALL MEDICATIONS MUST BE BROUGHT TO THE SCHOOL BY: _____**

If there are any other medical issues/concerns you would like the school employees attending trip to be aware of please provide details:

_____

_____

In my absence and if I cannot be reached in the event of an emergency, I being the parent/guardian of the above minor do hereby give permission for any emergency medical, dental or surgical care to be given. I assume all responsibility for this designation and hold the school district harmless from any liability that may result from this designation. Copies of this authorization may be presented to the admissions office of a hospital or clinic or to a physician or dentist. Other distribution shall be only within the limitations of the Family Educational Rights and Privacy Act.

_____ _____ _____ _____

(Parent/Guardian Signature) **(Print Name)** **(Date)** **(Phone)**