

PLEASANTON UNIFIED SCHOOL DISTRICT  
STUDENT FIELD TRIP AUTHORIZATION  
EMERGENCY MEDICAL INFORMATION

Form 6153C  
(Appendix C)  
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Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_ Student ID#: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone #1: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Dentist Phone: \_\_\_\_\_

Name of Medical Insurance Company: \_\_\_\_\_

Group/Coverage Number: \_\_\_\_\_

Allergic to the following: \_\_\_\_\_

Taking the following medication(s) at home: \_\_\_\_\_

List medications your student needs during the field trip:

1. \_\_\_\_\_

- Already in Health Office       Parent will provide medication with Medication Consent Form (required for prescription and over the counter medications)

2. \_\_\_\_\_

- Already in Health Office       Parent will provide medication with Medication Consent Form (required for prescription and over the counter medications)

3. \_\_\_\_\_

- Already in Health Office       Parent will provide medication with Medication Consent Form (required for prescription and over the counter medications)

Special Instructions:

\_\_\_\_\_  
\_\_\_\_\_

I hereby give my consent to the Pleasanton Unified School District, to whose care my child has been entrusted, the authorization for any emergency medical treatment, including any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care needed to be rendered on the advice of any physician, surgeon, medical practitioner, or under the provisions of the Dental Practice Act.

\_\_\_\_\_  
Signature of Parent/Guardian Date

\_\_\_\_\_ received medications from parent      \_\_\_\_\_ returned medications to parent

initial & date  
Field Trip Form 6153C

Distribution: Copy: Field Trip Teacher

initial & date  
Copy: School Attendance Office