Jackson Local Schools

Medical Consent, Release and Assumption of Risk
(International Travel)

Participant's Name: _____

As used herein: JACKSON LOCAL SCHOOLS shall include officers, directors, employees, staff, and designated chaperones "UNDERSIGNED" shall be the father and/or mother, or the guardian of PARTICIPANT, or the PARTICIPANT if eighteen years of age or older.

The UNDERSIGNED understand that during the field trip under the direction of JACKSON LOCAL SCHOOLS, certain risks and dangers may occur, including, but not limited to, hazards, accidents or illness of any kind whether foreseeable or unforeseeable, the forces of nature, and travel by airplane, automobile, bus, train, or other conveyance. The UNDERSIGNED understand that many activities associated with the field trip and related activities may take place in remote places without medical facilities.

The consideration of the right to participate in the field trip and related activities and to utilize the services, including food, as provided, the UNDERSIGNED hereby assume all risks, including those set forth above, and hereby hold JACKSON LOCAL SCHOOLS harmless from any and all liability, actions, causes of actions, debts, claims, and demands of every kind and nature whatsoever whether foreseeable or unforeseeable, which arise from or in connection with the above described field trip and related activities. This release and assumption of risk shall apply to the negligent acts or omissions of JACKSON LOCAL SCHOOLS. The terms hereof shall serve as a release and assumption of risk for the UNDERSIGNED, his or her heirs, executors, administrators, and members of the UNDERSIGNED's family.

In the event emergency medical treatment is required for the PARTICIPANT, while PARTICIPANT is under the control and direction of JACKSON LOCAL SCHOOLS, and if consent is requisite to any such treatment for the PARTICIPANT on behalf of the UNDERSIGNED, said consent may be granted or withheld by JACKSON LOCAL SCHOOLS as each of them, in their sole direction, shall determine. The UNDERSIGNED hereby waive any and all claims, which they may have against JACKSON LOCAL SCHOOLS arising from the granting or the withholding of the aforesaid consent.

In the event that emergency medical treatment is provided to the PARTICIPANT, the UNDERSIGNED hereby authorize JACKSON LOCAL SCHOOLS, and/or any other entity providing medical services or material in conjunction with emergency medical treatment, to seek payment for said services or material and assigns any medical, insurance benefit for the same services or material to JACKSON LOCAL SCHOOLS from the following insurers of the PARTICIPANT:

_____ _____

INSURER NAME POLICY NUMBER

The UNDERSIGNED hereby guarantee payment of any medical insurance deductible, any service not covered by PARTICIPANT's insurer, or any other cost incurred in providing emergency medical treatment, to JACKSON LOCAL SCHOOLS, and/or any other entity providing or paying for medical services or material in conjunction with emergency medical treatment.

The UNDERSIGNED below have read the Medical Consent, Release and Assumption of Risk and hereby voluntarily agree to the same, and have answered all questions on the Medical History Form (reverse side), to the best of his or her ability:

_____ _____

STUDENT or PARTICIPANT DATE

_____ _____

PARENT(S) or GUARDIAN(S) DATE

Sworn to me and subscribed by _____ in my presence the _____ day of _____, 20_____.

_____

NOTARY

Jackson Local Schools
Medial History Form
(International Travel)

All fields in this section *MUST* be completed.			
Last Name:	Full First Name:		Middle Name:
Gender:	Birthdate (MM/DD/YY):	Body Weight:	Country of Citizenship:
Passport Number:	Passport Expiration Date (MM/DD/YY):	Student Visa Number & Expiration Date (MM/DD/YY) Green Card Number & Expiration Date (MM/DD/YY):	

Student Address:		
City:	State:	Zip Code:
Daytime Phone:	Cell Phone:	Evening Phone:
School:		Current Grade/Grade Just Completed:
Parent/Guardian Name(s):		
Parent Address:		
City:	State:	Zip Code:
Daytime Phone:	Cell Phone:	Evening Phone:

MEDICAL INFORMATION

Indicate any ***CURRENT*** health conditions below (elaborate on a separate, attached sheet of paper, if necessary):

- ☐ **NO CURRENT HEALTH CONDITIONS**
- ☐ Food allergies: _____ Epi-pen ☐ yes ☐ no
- ☐ Medication allergies: _____
- ☐ Bee and/or wasp sting allergies Epi-pen ☐ yes ☐ no
- ☐ Other allergies: _____ Epi-pen ☐ yes ☐ no
- ☐ Asthma – uses emergency inhaler ☐ yes ☐ no
- ☐ Cancer
- ☐ Diabetes
- ☐ Seizures
- ☐ Bleeding disorder
- ☐ Celiac/gluten-free
- ☐ ADHD/ADD
- ☐ Hearing difficulties – has hearing aids ☐ yes ☐ no
- ☐ Vision difficulties – wears ☐ glasses ☐ contacts
- ☐ Heart problems (be specific): _____
- ☐ Physical disabilities (be specific): _____
- ☐ Previous concussion/head injury (year): _____
- ☐ Behavior/emotional issues: _____
- ☐ Other health conditions (be specific): _____

List any *current* medications (**all medications** must be in their original containers): _____

_____

Have you had any surgeries in the past year? _____ If so, please describe: _____

Date of last tetanus shot/booster (TDaP): _____ Date of last dental exam: _____

Are you a vegetarian? _____ List any dietary restrictions: _____

Do you have any physical impairments/restrictions that might your ability to participate in this program? _____ If yes, please explain: _____

Indicate other special considerations that we should be aware of: _____

_____

In the event of either illness or an accident, we will attempt to contact the parent/guardian and/or family health practitioner.

Health Care Provider Name:		Phone:
Emergency Contact:	Relationship:	Phone:

IMPORTANT: THIS FORM MUST BE COMPLETED, NOTARTIZED, AND RETURNED TO THE TRIP COORDINATOR BY THE SCHEDULED DUE DATE!