



Madison Public Schools
Madison, CT 06443

Student Travel Medical Form

School: DHHS _____ Principal: Salutari _____

Date(s) of Trip: See attached _____ Trip Organizer(s): Soja _____

Destination of Trip: See attached _____

Student Name: _____ Grade / Teacher: _____

Medical Concerns: _____

Student's Physician: _____ Phone: _____

Parent / Guardian Phone Numbers in Case of Emergency:

Parent / Guardian Name: _____ Parent / Guardian Name: _____

Home / Work / Cell: _____ Home / Work / Cell: _____

Will your child require medication during this trip? Yes No

Medications currently stored in the Health Office and authorized by the student's health care provider and parent authorization form will be sent on school trips. If additional medication is required, please provide the proper authorizations and medications per state regulations.

Should an emergency arise, your child will be transported to the nearest emergency facility and you will be notified as soon as reasonably possible.

Parent / Guardian Signature: _____ Date: _____