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MST Consent To Treat Form 08-08.doc

**Meritas Student Travel
Consent to Treat Form
7th Grade Trip- Washington, D.C
April 17-21, 2017**

This is to certify that on this date, I _____, as parent or guardian of _____, (trip participant), give my consent to Meritas LLC, all Meritas affiliated schools, and its medical representative to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant, for any injury or illness that could arise from participation in Meritas travel events. **All charges incurred for any medical expenses for treatment/services rendered NOT covered by guardian/student health insurance will be billed to the student account accordingly.**

If said participant is covered by any insurance company, please complete the following:

Insurance Company: _____

Policy Number: _____

Parent/Guardian Signature: _____ **Date:** _____

EMERGENCY CONTACTS:

1. Name: _____ Relationship: _____ Phone: _____
Address: _____

2. Name: _____ Relationship: _____ Phone: _____
Address: _____

Physician's Name: _____ Phone: _____

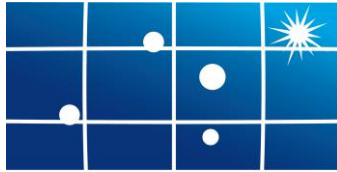
Do you have any drug allergies? Yes No If Yes, which drug(s) _____

Have you had (or do you currently have) any of the following?

Have you had a recent tetanus booster? Yes No If Yes, when? _____

Are you currently taking any medications? Yes No If Yes, please list all medications.

Has a doctor placed any restrictions on your activity? Yes No If Yes, please explain. _____



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Forms\MST OTC Medical Form 08-08.doc

Meritas Student Travel
Authorization for Over the Counter Medication
7th Grade Trip- Washington, D.C
April 17-21, 2017

I hereby give the Health Care Manager or his/her designee permission to apply or give one or more of the following over the counter medications or external preparations, in accordance with the directions for use on the container.

Student's Name: _____

___ Tylenol ___ Advil ___ Aspirin ___ Motrin

___ Antibiotic Ointment

___ First aid spray

___ Any other OTC medications your child may need

List provided items _____

Special Directions:

Note: All medications need to have your Student's name on them and be in the **original packaging** with doses and directions for administration. All medications must be supplied by parents and given directly to the designated chaperone/health care manager. In the event it is necessary to purchase specific medication while on the trip, your school account will be billed for the cost.

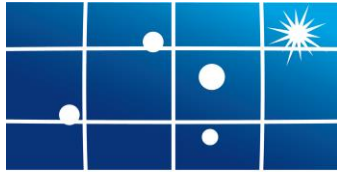
I/we release Meritas LLC, the staff of Meritas Student Travel and all Meritas affiliated Schools from any liability for administering these over the counter medication.

Parent Signature: _____

Print Name

Signature

Date



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M:\MST Medical Prescription 08-08.doc

Meritas Student Travel Authorization for Prescription Medication

7th Grade Trip- Washington, D.C
April 17-21, 2017

Name of Student

Diagnosis

Date

Medication & Dosage Prescribed

INSTRUCTIONS for Administering and Side Effects:

ALL MEDICATION MUST BE IN ORIGINAL CONTAINER INDICATING THE STUDENTS' NAME ON THE PRESCRIPTION LABEL.

PHYSICIAN INFORMATION

Print Name:

Signature of Physician (Required):

Date:

Phone Number:

PARENTAL PERMISSION (to be completed by Parent or Guardian)

I grant the Health Care Manager or his/her designee permission to assist in the administration of each prescribed medication to be provided.

I/we release Meritas LLC, Meritas Student Travel and all Meritas affiliated schools from any liability for administering these prescription medications.

Signature of PARENT/GAURDIAN:

Print Name:

Date:

Phone Number:
