

# REQUIRED FOR OVERNIGHT TRIP PARTICIPATION

## Student Medical Authorization and Insurance Form

Student Name: \_\_\_\_\_ Student Birth Date: \_\_\_\_\_

I, \_\_\_\_\_ am the lawful legal guardian of the student named above and give them permission to participate in the Lakeshore Middle School – Washington, DC Trip from February 27-March 1, 2020.

Should my child sustain or incur any accident or illness while attending this trip, I hereby authorize Lakeshore Middle School Staff Members to perform reasonably Good Samaritan actions or execute any documents, including any necessary releases, which might be required by any medical facility to perform any emergency care in my behalf. In the event that my child has an illness or accident during the trip, which requires a visit to the doctor or hospital, the existing family or school policies will represent the primary insurance coverage.

I understand that Lakeshore Middle School Staff may dismiss my child from the trip if, in their opinion, his or her conduct is not in the best interest of the entire group. I also understand that I am responsible for transporting my child in the case of a discipline or medical problem where the school leaders deem it necessary for the student to return home.

### **Insurance Information: This section to be completed by the Parent or Guardian.**

Is your student covered by a health or accident insurance policy? Yes \_\_\_ No \_\_\_

If "yes," list policy type (school or other) \_\_\_\_\_

Address of Insured (Student) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### **Name and Address of Employer/Employee that provides coverage:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### **Name and Address of Insurance Company (Address to submit claims)**

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number of Company (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Agent \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature (Required) \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

Parent Emergency Contact Phone Number \_\_\_\_\_