Field Trip Student Health History

Student's Name _____ Date of Birth _____

Parent/Guardian Name(s) _____ Home Ph # _____

Work Ph # _____

Cell Ph # _____

EMERGENCY CONTACTS:

Name _____ Phone # _____

Name _____ Phone # _____

Family Doctor _____ Phone # _____

Insurance Company _____

Policy Holder's Name _____ ID/Group Number _____

HEALTH HISTORY

Surgeries or hospitalization (within the last year) _____

Tetanus (last injection) _____

_____ADHD _____Diabetes _____Asthma _____Seizures

Other health conditions _____

List any allergies (medications, foods, insects, etc.):

Allergen _____ Reaction _____ Treatment _____

Allergen _____ Reaction _____ Treatment _____

List any medications to be given on the field trip:

MEDICATION	DOSAGE	TIME TO BE GIVEN	REASON

**CHECK ONE: _____Parent sending medicine _____Send from Health room

*PLEASE NOTE: All above medications that need to be administered to your child during this trip will need to be brought by a parent to the school nurse in the original pharmacy labeled container no later than 2 days prior to trip.

I authorize the District Representative to administer the above listed medications while on this trip. In case of a medical emergency, I hereby give permission to the District Representative to secure proper treatment for my child, and, if I can not be reached, give permission to the physician/hospital for any medical or surgical emergency. I understand that I will be responsible for any medical bills or hospital expenses incurred.

Custodial Parent/Guardian Signature: _____ Date _____