EXTENDED DAY AND OVERNIGHT FIELD TRIP AND FOREIGN TRAVEL
EMERGENCY PROCEDURE/HEALTH INFORMATION

STUDENT'S NAME _____ MALE_____ FEMALE_____

LAST NAME FIRST NAME MIDDLE INITIAL

SCHOOL _____ GRADE _____ DATE OF BIRTH _____

STREET ADDRESS _____

CITY _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

FAMILY PHYSICIAN _____ PHONE _____

PARENT/GUARDIAN NAME _____

EMERGENCY NOTIFICATION

(List in order of Notification - Parent/Guardian will be contacted first unless otherwise specified.)

MAJOR EMERGENCIES WILL BE TAKEN TO THE NEAREST HOSPITAL

_____

NAME OF PERSON RELATIONSHIP PHONE NUMBER

_____

NAME OF PERSON RELATIONSHIP PHONE NUMBER

HEALTH INFORMATION

(Please list & give dates if known)

Health conditions/operations:

Handicapping Conditions:

Allergies (medication, food, insects, etc.):

Describe the usual **symptoms/reactions**:

Medications (prescription and non-prescription):

If prescription or over-the-counter medication is to be taken, a written order from your Doctor is required. (See back) There will not be a nurse in attendance on this trip.

Does your child have any activity restrictions? Yes_____ No _____ If yes, please explain.
Does your child have dietary restrictions? Yes_____ No _____ If so, what are restrictions?

PARENT/GUARDIAN SIGNATURE _____ DATE _____

The information you provide will be handled in a confidential manner. Information provided on this form will be shared with staf necessary to maintain your child's safety.

INSURANCE COMPANY _____ POLICY OR BINDER NUMBER _____

PERMISSION IS GRANTED FOR TREATMENT OF THE ABOVE NAMED PARTICIPANT BY A PHYSICIAN AND/OR HOSPITAL FOR ANY MEDICAL OR SURGICAL EMERGENCY.

PARENT/GUARDIAN SIGNATURE _____ DATE_____

FOR FOREIGN TRAVEL STUDENTS ONLY

Provide last date of immunization:
DTP_____ Polio _____ Hib _____ MMR _____ Varicella_____ Hepatitis B_____

Physician Signature_____ Date_____