Health Form

Event/Field Trip_____

Trip Date(s)_____Location_____

Student's Name_____ Birth date_____

Address_____ Phone_( )_____

Emergency Phone Numbers

Parent or Guardian_____Phone_( )_____

Parent or Guardian_____Phone_( )_____

Emergency Contacts (in case parent/guardian is not available)

Name_____Phone_( )_____Relation_____

Student's Physician_____Phone_( )_____

Student's Dentist_____ Phone_( )_____

Parent(s)/Guardian will assume the full cost of any medical or hospital expenses incurred. Medical payment coverage and reimbursement for said child is as follows:

Health Insurance/Medical Relief Coverage_____

Address _____

_____

_____

Policy Number _____Phone_( )_____

Important Health Information

1. Do you know of any health factors that limit or exclude your child from participating in the physical activities for this event/field trip? If unsure of the range of physical activities, please consult your child's teacher. Yes_____ No____

If yes, please explain _____

_____

2. Has your child had any serious illnesses, operations, hospitalizations or serious accidents during the past year?

Yes____ No____ If yes, please explain _____

3. Date of last tetanus shot_____

4. Does your child have any allergies or special health problems? Yes___ No___ If yes, please explain_____

_____

5. Is your child receiving any medication either at home and/or at school? Yes____ No____If yes, please explain

_____

6. Does your child have an individual health plan or emergency plan in place during the school day? Yes___No___

(If yes, the teacher should contact the health service office before the trip.)

Authorization to Administer Medication

(Note: refer to District's procedure for administration of medication)

If the student is not currently authorized to take or be administered the medication during the school day, a physician must complete the section below for all prescription and over-the-counter medications. If the student is currently authorized to take or be administer the below listed medication during the school day, the section can be filled out by the parent/guardian and doe not need to be completed by a physician.

Name of Medication Dose Method Route Time to be given

_____

_____

_____

Possible side effects from above medication_____

_____

_____

It is acceptable for the student to carry medication on his/her person. Yes___ No___

It is acceptable for the student to administer his/her own medication. Yes___ No___

Physician's Signature_____Date_____

Address_____Phone__( )_____

I/(We) the undersigned parent(s)/guardian of _____grant and assign staff member of AH#11 the authority and consent to sign medical emergency release documents both for doctors and hospitals on behalf of our child, and grant and assign to them permission and consent for emergency medical treatment, operation, administration of anesthesia, blood transfusion, or urgent medical treatment of any illness or injury that any qualified medical practitioner may deem necessary for our child's welfare in the event the parent(s)/guardian can not be contacted.

I/(We) request and authorize my child to be responsible to self-administer medication during this event; thereby, releasing school personnel and chaperones from liability should inappropriate usage and/or restrictions result from the medications. Yes___ No___

I/(We) further understand that staff members and/or chaperones will notify the parent(s)/guardian of any medical treatment as soon as possible. (For out-of-state travel, the signature of all parties having legal custody of the student is required.

Signature of parent(s)/guardian_____Date _____

Signature of parent(s)/guardian_____Date _____
