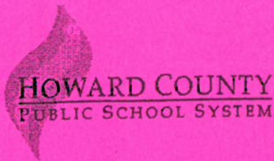

EMERGENCY PROCEDURE/HEALTH INFORMATION for EXTENDED DAY, OVERNIGHT FIELD AND FOREIGN TRAVEL TRIPS

MUST BE COMPLETED BY PARENT FOR ANY STUDENT ATTENDING TRIP

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 separate written order from your physician specific to Medication Form/Physician's Order (IFAS# 39513035) is required. Refer to attached Medication/Treatment Order. MEDICATION MUST BE PROVIDED FROM HOME. There will not be a school 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 staff as 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______________________