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

MUST BE COMPLETED BY PARENT FOR ANY STUDENT ATTENDING TRIP

STUDENT'S NAME ____ MALE____________

LAST NAME FIRST NAME MIDDLE INITIAL FEMALE__________

NON-BINARY_____________

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:____

Other Conditions/Concerns:____

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 (Workday #3035-1) 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 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:** __________________