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

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):

For any daily medication that may be needed outside regular school hours, a separate written order form from the physician/prescriber and medication from home must be provided. For daily medications needed during the school day and any as needed medication on file in the health room, the School Nurse/Health Assistant will provide copies of existing medication orders and medication for use. 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? _____

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** _____

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