



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
LAST NAME FIRST NAME MIDDLE INITIAL
MALE FEMALE
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