

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

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
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NAME OF PERSON	RELATIONSHIP	PHONE NUMBER
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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 written order from your Doctor is required. (See back) There will not be a 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 _____