MEDICAL INFORMATION

Your Child's Name: ____

Name and # of Medical Plan: _____________________________________

Doctor's Name and Phone #: _____________________________________

List any ailments, disabilities, health issues or problems involving your child which might affect his/her participation in the field trip:

Asthma _____	Ear Infection _____	Sleepwalking ___
Allergies ____	Epilepsy ________	Sinus _________
Bronchitis ___	Heart Disease ____	Other _________

Please explain any checked items needing clarification (e.g., "Allergies" or "Other"):

____

____

All medication is to be administered by the trip supervisor or teacher/staff chaperone. Medication must be clearly labeled with the student's name, the name of the medication, what it is to be used for, how it is to be given, the quantity to be given, and the time(s) of day/night it is to be given. Only the amount of medication required for the duration of the trip should be provided.

Name of medication: ____

What it is to be used for: ____

How it is to be given: ____

Quantity and times to be given: _____________________________________

Comments: ____

By my signature below, I am requesting that the trip supervisor or teacher/staff chaperone administer this (these) medication(s) as directed above.

Parent/Guardian Signature: ______________________________ Date: ________

IN CASE OF EMERGENCY: I hereby request the physician/emergency team selected by the trip supervisor to provide treatment for my child named above.

Parent/Guardian Signature: ______________________________ Date: ________

IF PARENT/GUARDIAN CANNOT BE REACHED IN AN EMERGENCY, PLEASE CONTACT (please print clearly):

Name: ____________________________________ Phone #: ________________