Health History for OVERNIGHT Field Trips

Student Name:_____ Birthdate: _____

Address: _____

Parent/Guardian(1): _____ Phone Number Cell:_____ Work: _____

Parent/Guardian(2): _____ Phone NUmber Cell:_____ Work:_____

Physicians' Name: _____ Phone Number: _____

In the event that we would not be able to contact you, please list two (2) alternate names to call.

Alternate (1): _____ Phone Number: _____

Relationship: _____

Alternate(2): _____ Phone Number: _____

Relationship: _____

To Assist the chaperones in providing careful supervision of the health and safety of your child, please advise of any conditions needing attention. To the best of my knowledge, _____ is in good health and free of any communicable disease. **Date of last tetanus booster:** _____

Has your child been diagnosed with any of the following conditions by a Healthcare Provider (check all that apply)?		
☐ ADD/ADHD	☐ Emotional/Behavioral/ Psych	☐ Heart Condition
☐ Asthma	☐ Headaches/Migraines	☐ Epilepsy/ Seizures
☐ Diabetes	☐ Orthopedic	☐ Other: _____
Details/Specifics regarding conditions:		

Allergies		
☐ Food	*Specifics:*	Does your child require Emergency Epinephrine:Yes/No Will your child self administer this Epinephrine? Yes/No Does your child require oral antihistamine? Yes/NO *If yes to any of the above questions, the medications will need to be provided by the parent/guardian and a medication consent or prescription medication form is required in order for staff to administer*
☐ Insect	*Specifics:*	
☐ Seasonal		
☐ Other	*Specifics:*	

Does your child have a problem with:			
Motion Sickness	Yes No	Sleep Walking	Yes No

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MEDICATION: Is your child currently taking any medications?		
Name of medication:	*Reason for medication*	*When is it given?*
Name of medication:	*Reason for medication*	*When is it given?*
Name of medication:	*Reason for medication*	*When is it given?*

*************If prescription medication is being taken, the student should bring the medication in its prescription bottle. We will also need the prescription medication form completed before administering.***

In the event of EMERGENCY CONDITIONS, the following procedures will be followed:

1. Emergency first aid will be given by the teacher, chaperone, or other qualified person.
2. In the case of serious injury.illness: the child will be transported to the nearest hospital for examination by a healthcare provider.
3. Reasonable effort will be made at contacting parent/guarding referenced above.

In the event I am unable to be reached, I hereby consent to my child's treatment as recommended by the physician/hospital. I understand that I as parent/guardian am responsible for the cost of the services rendered.

Insurance Provider: _____

Insurance Provider Phone number: _____

Name of Subscriber: _____

Policy number: _____

_____ _____

Parent/Guardian Signature Date