HEALTH HISTORY MEDICAL RELEASE

To be completed for ALL students attending trip

PART 1: TO BE COMPLETED BY PARENT/CUSTODIAL GUARDIAN

____

PARTICIPANT'S LAST NAME FIRST MIDDLE BIRTH DATE

____

STREET ADDRESS CITY STATE ZIP CODE

________________________(_____)__________________(_____)_________________(_____)____________

MOTHER'S NAME BUSINESS PHONE CELL PHONE HOME PHONE

________________________(_____)__________________(_____)_________________(_____)____________

FATHER'S NAME BUSINESS PHONE CELL PHONE HOME PHONE

If not available in an emergency please notify:

________________________(_____)__________________(_____)_________________(_____)____________

NAME/RELATIONSHIP BUSINESS PHONE CELL PHONE HOME PHONE

PART 2: HEALTH HISTORY TO BE COMPLETED BY PARENTS

Please circle answer that applies.

My child is currently taking medications:	**NO**	**YES***	***If YES, please refer to Medication Administration form**
My child has Medication Allergies (please list):	**NO**	**YES***	***If YES, please refer to Allergies/Anaphylaxis Medication Administration form**
My child has Food Allergies:	**NO**	**YES***	***If YES, please refer to Allergies/Anaphylaxis Medication Administration form**
My child has other Allergies: (Include insect stings, hay fever, etc.)	**NO**	**YES***	***If YES, please refer to Allergies/Anaphylaxis Medication Administration form**

****Please see reverse side to complete Health History Medical Release**

My child has Asthma **NO** **YES*** ***If YES, please refer to Asthma Medication Administration form**

My child is under the care of a physician for the following condition(s): ___________________________________

____

My child has medical conditions the school/chaperones should be aware of: ______________________________

____

Date of last Tetanus Immunization: ______________________

PART 3: FAMILY HEALTH INSURANCE INFORMATION

(Please be aware that few doctors will directly bill out of state patients.)

Carrier: ____________________________ **Group #:** _______________________ **Policy #:** __________________

Carrier Address:____ **Insured:** __________________

Relationship to Insured: ____ **I.D. #:** ________________________

PART 4: TO BE SIGNED BY PARENT/GUARDIAN

(Must be signed for your child to participate in the field trip)

I hereby give permission for my child's sponsoring organization (i.e. school)/chaperones to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering X-rays and routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission for my child's sponsoring organization/chaperones to arrange necessary related transportation for my child. In the event I can not be reached in an emergency, I hereby give permission to the physician selected by my child's sponsoring organization/chaperones to secure and administer treatment, including hospitalization, for the person named above. I understand that none of the tour company, the sponsoring organization or chaperones are responsible for the quality of any such medical treatment.

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SIGNATURE OF PARENT/GUARDIAN

____ __________________

PRINTED NAME **DATE**