IFAS 39502236

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

MUST BE COMPLETED BY PARENT FOR ANY STUDENT ATTENDING TRIP

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

_____

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 for Extended Day and Overnight Field Trip(s) and Foreign Travel 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_____

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