

MEDICAL INFORMATION AND AUTHORIZATION

Student Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Parent's Full Names \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Emergency Number \_\_\_\_\_

Health Insurance (Give Company, policy name, and ID numbers \_\_\_\_\_

\_\_\_\_\_

Date of last tetanus booster \_\_\_\_\_

List any special health conditions ( such as diabetes, epilepsy, bleeding tendency, allergies, etc.)

your child has \_\_\_\_\_

List medications to which the student is allergic or cannot take \_\_\_\_\_

\_\_\_\_\_

List any medications you child must take during the time of the field trip \_\_\_\_\_

\_\_\_\_\_

I hereby authorize the personnel in charge of this field trip to release the above information to medical authorities and to obtain medical care and/or hospitalization should illness or accident occur while my child is engaged in this field trip. I accept the responsibility for payment of any medical expenses.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

To be retained by field trip personnel