

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

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

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**HEALTH INFORMATION**

**(Please list & provide 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 written order from your Doctor is required. (See back) There will not be a 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 _____