HEALTH HISTORY MEDICAL RELEASE

PART 1: **TO BE COMPLETED BY PARENT/CUSTODIAL GUARDIAN**

PARTICIPANT'S LAST NAME _____ FIRST _____ MIDDLE _____ BIRTH DATE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

FATHER'S NAME _____ ( ) BUSINESS PHONE _____ ( ) CELL PHONE _____ ( ) HOME PHONE _____

MOTHER'S NAME _____ ( ) BUSINESS PHONE _____ ( ) CELL PHONE _____ ( ) HOME PHONE _____

If not available in an emergency please notify:

RELATIONSHIP _____ ( ) BUSINESS PHONE _____ ( ) CELL PHONE _____ ( ) HOME PHONE _____

PART 2: **HEALTH HISTORY TO BE COMPLETED BY PARENTS**

NO YES

☐ ☐ **My child is currently taking medications:**

☐ ☐ Med # 1 _____ Dosage _____ Reason _____

☐ ☐ Med # 2 _____ Dosage _____ Reason _____

☐ ☐ **My child has Medication Allergies (please list):** _____

☐ ☐ **My child has Food Allergies:** _____

☐ ☐ **My child has other Allergies:** _____

(Include insect stings, hay fever, asthma, etc.)

☐ ☐ **My child is under the care of a physician for the following condition:** _____

_____

☐ ☐ **My child has medical conditions the school/chaperones should be aware of:** _____

_____

Date of last Tetanus Immunization: _____

Students are permitted to bring over the counter drugs as long as they are in a small, sealed container.

If you do not wish to allow your child to bring his/her own over the counter drugs, please sign here. _____

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 on the field trip)**

I hereby give permission to my child's 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 to my child's school/chaperones to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by my child's school/chaperones to secure and administer treatment, including hospitalization, for the person named above.

_____

SIGNATURE OF PARENT/GUARDIAN

_____ _____

PRINTED NAME DATE