

****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

<input type="checkbox"/> NO	<input type="checkbox"/> YES	My child is currently taking medications:
<input type="checkbox"/>	<input type="checkbox"/>	Med # 1 _____ Dosage _____ Reason _____
<input type="checkbox"/>	<input type="checkbox"/>	Med # 2 _____ Dosage _____ Reason _____
<input type="checkbox"/>	<input type="checkbox"/>	My child has Medication Allergies (please list): _____
<input type="checkbox"/>	<input type="checkbox"/>	My child has Food Allergies: _____
<input type="checkbox"/>	<input type="checkbox"/>	My child has other Allergies: _____ (Include insect stings, hay fever, asthma, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	My child is under the care of a physician for the following condition: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	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 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 can not 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