

## HEALTH HISTORY FOR OUT-OF-STATE OR OVERNIGHT SCHOOL FIELD TRIPS

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Home Telephone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

Person to be called in case of emergency if parent/guardian cannot be reached:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Last Tetanus Shot: \_\_\_\_\_

Please list any allergies (bee sting, medications, etc.) or illness that the school should be aware of: \_\_\_\_\_

Medications student is currently taking: \_\_\_\_\_

Any special information/instructions concerning medication: \_\_\_\_\_

I hereby give my permission for non-prescription medication (for example: aspirin) to be given to my child \_\_\_\_\_ if deemed advisable by designated school personnel.

**IN CASE OF SURGICAL EMERGENCY:** I hereby give permission to the physician selected by the school director, or in his absence, his designee, to hospitalize, secure treatment for, and to order injections, anesthesia, or surgery for my child as named above.

Any directions to the contrary should be specified on the reverse side of this form and signed.

all band/guard activities for school year 2010-2011  
Activity

Parent/Guardian Signature \_\_\_\_\_