

**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 and colorguard activities for school year 2009-2010
Activity

Parent/Guardian Signature _____