

**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

**HEALTH INFORMATION**  
(Please list & give 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 \_\_\_\_\_

**EXTENDED DAY AND OVERNIGHT FIELD TRIP AND FOREIGN TRAVEL  
MEDICATION/TREATMENT ORDER**

**THIS SIDE TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER**

Dear Health Care Provider:

Your patient will be participating in an approved trip to \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_. There will not be a nurse in attendance (date and time) (date and time) on this trip. If you have any concerns about your patient's health needs on this trip, please contact the cluster nurse at \_\_\_\_\_. **Please indicate below any treatment/prescription and/or over-the-counter medications that your patient is currently taking and will need to continue to take while on the trip.** This form must be returned two weeks prior to the trip date to provide for planning and staff training.

\_\_\_\_\_

Student's Name

Date of Birth

**To be completed by the Physician**

Medication/Treatment	Dosage/Frequency of Administration	Circumstances/symptoms for administration	Diagnosis

\_\_\_\_\_ Student may carry and self-administer medication.

**Signed by prescribing health care provider:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**To be completed by designated school personnel**

Medication/Treatment	Date/Time Medication Given	Date/Time Medication Given	Date/Time Medication Given	Signature of Designated School Personnel