

**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
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\_\_\_\_\_  

NAME OF PERSON	RELATIONSHIP	PHONE NUMBER
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**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 \_\_\_\_\_