



FIELD TRIP MEDICAL FORM

Required for overnight or extended day field trips

Student Name: _____ Age: _____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Name of Parent/Guardian: _____

Home Phone: _____ Work Phone _____ Cell Phone _____

Physician _____ Phone _____

In case of emergency, notify the following if unable to contact parent/guardian:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Insurance Information: Company _____

Policy Holder: _____ Policy Number _____

Health Considerations: _____

Allergies: _____

Dietary Restrictions: _____

A Medication Permission Form signed by the parent/guardian is required for all medications. **Prescription**

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