

****HEALTH HISTORY MEDICAL RELEASE****

PART 1: TO BE COMPLETED BY PARENT/CUSTODIAL GUARDIAN

PARTICIPANT'S LAST NAME	FIRST	MIDDLE	BIRTH DATE

STREET ADDRESS	CITY	STATE	ZIP CODE
_____	_____	_____	_____
FATHER'S NAME	BUSINESS PHONE	CELL PHONE	HOME PHONE
_____	_____	_____	_____
MOTHER'S NAME	BUSINESS PHONE	CELL PHONE	HOME PHONE
_____	_____	_____	_____
RELATIONSHIP	BUSINESS PHONE	CELL PHONE	HOME PHONE
_____	_____	_____	_____

If not available in an emergency please notify:

PART 2: HEALTH HISTORY TO BE COMPLETED BY PARENTS

NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	My child is currently taking medications:
<input type="checkbox"/>	<input type="checkbox"/>	Med # 1 _____ Dosage _____ Reason _____
<input type="checkbox"/>	<input type="checkbox"/>	Med # 2 _____ Dosage _____ Reason _____
<input type="checkbox"/>	<input type="checkbox"/>	My child has Medication Allergies (please list): _____
<input type="checkbox"/>	<input type="checkbox"/>	My child has Food Allergies: _____
<input type="checkbox"/>	<input type="checkbox"/>	My child has other Allergies: _____ <small>(Include insect stings, hay fever, asthma, etc.)</small>
<input type="checkbox"/>	<input type="checkbox"/>	My child is under the care of a physician for the following condition: _____
<input type="checkbox"/>	<input type="checkbox"/>	My child has medical conditions the school/chaperones should be aware of: _____
Date of last Tetanus Immunization: _____		

PART 3: FAMILY HEALTH INSURANCE INFORMATION

(Please be aware that few doctors will directly bill out of state patients.)

Carrier _____	Group # _____	Policy # _____
Carrier Address _____	Insured _____	
Relationship to Insured _____	I.D. # _____	

PART 4: TO BE SIGNED BY PARENT/GUARDIAN

(Must be signed for your child to participate on the field trip)

I hereby give permission to my child's school/chaperones to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to my child's school/chaperones to arrange necessary related transportation for my child. In the event I can not be reached in an emergency, I hereby give permission to the physician selected by my child's school/chaperones to secure and administer treatment, including hospitalization, for the person named above.

SIGNATURE OF PARENT/GUARDIAN

PRINTED NAME

DATE