

Student Health History

School: _____ Age: _____ Date: _____

Name: _____
Last First Middle Initial

Male: _____ Female: _____ Date of birth: _____

Student Health History Cont.

Please describe and provide dates if known.

Surgery (within last 3 years): _____

Emotional concerns: _____

Please describe and provide dates if known.

Serious medical problems: _____

Rheumatic fever: _____

Diabetes: _____

Allergies: _____

Tetanus (date of last immunization): _____

Any special health problems in the last year? Please specify: _____

Allergies to drugs? Please specify: _____

Other allergies? _____

Any other medical problems that may influence treatment? (If none, please state, "none known")

Current medication (Please include anti-convulsive, antihistamine, insulin, anti-depressants, and tranquilizers): _____

Please list any non-prescription meds students will have on trip _____

Is student under medical treatment at present? Yes _____ No _____

Please specify: _____

Diet restrictions: _____

Please note: Each student taking medications on a daily basis, e.g., insulin, **must** report his or her medication intake to the designated chaperone and/or nurse *each day*

Family physician _____
Name Address Phone #

Family dentist _____
Name Address Phone #

As parent/guardian of _____,
(Print: name of student participant)

I authorize treatment of the above-mentioned student by a qualified physician or nurse in the event the student would require medical treatment. I understand that should a serious or life-threatening medical emergency arise, initial treatment of the student may be rendered by an individual, trained in first aid, if in the opinion of that individual, delay might endanger his/her life, cause disfigurement or undue comfort. On the Medical Information Form I have listed any allergies, ongoing medical treatment or medical problems, which might influence treatment of the student. I will be responsible for the charges incurred for the student's treatment. This permission is granted with the understanding that except in a serious medical emergency, a reasonable effort will be made to inform me prior to treatment.

Parent or legal guardian signature: _____

Please print name: _____

Medical Insurance Information

Insurance company/carrier (name, address, & phone number):

Name: _____

Address: _____

Phone: _____

Policy/Group number: _____

Member Number _____

Name of Responsible Party _____
