JEFF TECH

576 VO TECH ROAD
REYNOLDSVILLE, PENNSYLVANIA 15851-6368
(814) 6 5 3 - 8 2 6 5
FAX: (814) 6 5 3 - 8 4 2 5

Overnight Field Trip Health Form

Full Name_____ Date of Birth _____
Address _____
Home Phone_____ Cell Phone _____

Parent/Guardian _____
Home # _____ Work # _____ Cell #_____

EMERGENCY NOTIFICATION

(Parents will be contacted first)

Name _____ Relationship: _____ Phone # _____

Insurance Information

Insurance Company_____ Policy/Group Number _____

Health Information

Does the student have any of the following health conditions:

Allergies (Food, Drug, Environmental) _____

Reaction _____

Heart Defect/Disease _____

Diabetes _____

High Blood Pressure _____

Seizure Disorder _____

Bleeding/Clotting Disorders _____

Asthma _____

Migraines _____

Vision/Hearing Impairment _____

Other _____

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1. Does the student have any special dietary considerations? Yes No

If yes, please explain: _____

2. Provide any other important health related information about the studentt:

3. Does the student take any medicine on a daily or as needed basis? Yes No

If yes, please fill out the attached medication administration form/consent.

The information you provide will be handled in a confidential manner.

By signing below, you are agreeing the following items:

1. 911 or Emergency Medical Services will be called in the event of a medical emergency and the student will be transferred to the nearest medical facility.
2. Emergency care will be secured by the trip chaperones and every effort will be made to contact me before emergency care is given.
3. I will not hold the trip chaperones responsible for any medical emergencies that arise.
4. I give permission for treatment at a hospital or other medical facility in the event of a medical or surgical emergency.

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian:_____ Date: _____

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Medication Administration/Consent Form

My child needs to take the following medications for the duration of the field trip:

Medication:____________________Dosage:__________________Frequency:____________

Side effects to watch for: ____

Medication:____________________Dosage:__________________Frequency:____________

Side effects to watch for: ____

Medication:____________________Dosage:__________________Frequency:____________

Side effects to watch for: ____

Medication:____________________Dosage:__________________Frequency:____________

Side effects to watch for: ____

Medication:____________________Dosage:__________________Frequency:____________

Side effects to watch for: ____

Parent/Guardian Consent:

By signing below, I agree to the following:

1. I consent to have the trip chaperone(s) secure and administer the above medications for the duration of the field trip.
2. If it is an inhaler or Epi-Pen that needs to be with the student at all times, I agree to the statement "My child understands how to appropriately carry, self-administer, and secure the emergency medication."
3. All medications must be stored in their original containers or in a pharmacy-dispensed container *(a second labeled container can be obtained at the Pharmacy).*
4. I agree that I will provide only the amount of medication required for the duration of the field trip. No medication will be provided by the trip chaperones.

Printed Name of Parent/Guardian: _________________________

Signature of Parent/Guardian:____________________________ Date: ___________