

****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

My child is currently taking medications:

Med # 1 _____ Dosage _____ Reason _____

Med # 2 _____ Dosage _____ Reason _____

My child has Medication Allergies (please list): _____

My child has Food Allergies: _____

My child has other Allergies: _____
(Include insect stings, hay fever, asthma, etc.)

My child is under the care of a physician for the following condition: _____

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 sponsoring organization (i.e. 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 sponsoring organization/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 sponsoring organization/chaperones to secure and administer treatment, including hospitalization, for the person named above. I understand that none of the tour company, the sponsoring organization or the chaperones are responsible for the quality of any such medical treatment.

SIGNATURE OF PARENT/GUARDIAN

PRINTED NAME

DATE