

CENTRAL COMMUNITY SCHOOL TRIP HEALTH FORM

STUDENT/CHAPERONE NAME _____

PARENT(S)/GUARDIAN(S)/OTHER(S) _____

HOME PHONE _____ CELL PHONE _____

ADDITIONAL PHONE(S) _____

EMERGENCY CONTACT (IF ABOVE CONTACT CANNOT BE REACHED)

1) NAME: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

2) NAME: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

GENERAL HEALTH INFORMATION

1) PERTINENT EXISTING MEDICAL CONDITIONS: _____

2) MEDICATIONS TAKEN REGULARLY (INCLUDING OVER THE COUNTER)

(IF MEDICATION IS NEEDED ON THE TRIP, PLEASE FILL OUT MEDICATION AUTHORIZATION FORM IF NOT ALREADY ON FILE AT SCHOOL AND RETURN TO THE OFFICE WITH MEDICATION BY APRIL 1ST)

- NO MEDICATION NEEDED
- MEDICATION NEEDED

MEDICATION: _____ DOSE: _____

TIMES TO ADMINISTER: _____

MEDICATION: _____ DOSE: _____

TIMES TO ADMINISTER: _____

EX: TYLENOL 500 MG TAB, DOSE: 2 TABS OR 1000 MG, TIMES TO ADMINISTER: 8 AM, AND 2 PM.

3) KNOWN ALLERGIES/DRUG REACTIONS: _____

I understand that care and attention will be given to the health and comfort of the participants, but chaperones/staff cannot be held liable for any injuries sustained, which were not directly caused by their failure to take due care.

I (parent/guardian/chaperone) assume full responsibility for the applicant's health, being such that the activities will in no way aggravate any conditions present. If in doubt, medical advice will be sought and followed.

I hereby authorize chaperones/staff of the event to secure such medical advice and services as may be deemed necessary for the health and safety of my son/daughter. I agree to accept financial responsibility.

Signature _____ Date _____

(Parent/ Guardian/ Chaperone)