Form F-1

Cook County Schools Health Office

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Phone 218.387.2271 ext. 116

Overnight Field Trip Authorization and Student Health History Form

***To be completed by a parent or guardian**

Student's Name _____ Date of Birth _____

Grade _____ Teacher _____

Emergency Contact Information

Parent Name:		Contact Phone:
Parent Name:		Contact Phone:
Contact (non-parent) for emegency use:		Contact Phone:

Medical Care Information

Physician Name:		Clinic Name:
Clinic Contact Phone:	Insurance Carrier:	
	Insurance Policy Number:	
	Insurance Group Number	

Health Questionaire: (Check all that apply)

	Food (please list)
	Medication (please list)
	Bee Stings
	Seasonal/Environmental (please list)
	Other (please explain)
	No Known Allergies

Does the student have any physical limitations? If so, please explain. _____

_____

Does the student have any diet restrictions? If so, please explain. _____

_____

Please share any additional information necessary to support your student while away and in the care of school personnel. __

_____

_____

This form has been reviewed by ISD 166 teaching staff:

(Signature) _____ (Date of Review) _____

If medical condition or medication was indicated, Health Office staff was notified (circle one): Yes or No

Health Office Staff Notified _____ Date Notified _____

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Does your student have a history of, or currently is affected by: (Check all that apply)

	Asthma	Self Carry Inhaler?
	Bedwetting	Please explain extra cares:
	Bleeding Disorder	Special Instructions:
	Constipation	
	Diabetes	Please see health office to complete action plan.
	Emotional/Mental Health Condition	
	Painful Menstrual Cramps	
	Seizure Disorder	Please see health office to complete action plan.
	Sensory Supportive Devices	Glasses: Contacts Lenses: Hearing Aids:
	Fainting	
	Frequent Headaches or Migraines	What are some triggers: What can we do to help?
	Other:	
	None	No health conditions known to parent or guardian

Medication: Please check most appropriate statement:

_____ *My student DOES NOT need any medication on this field trip, prescription or non-prescription.*

_____ *YES, my student WILL NEED MEDICATION, but a parent will be chaperoning and will manage student medication. (no need to complete Form F2 Medication Authorization for Overnight Field Trips)*

_____ *YES, my student WILL NEED MEDICATION on this field trip. In order for field trip chaperones or school staff to admnister medication (prescription and over the counter) to the student, guardians/parents must complete Form F2 Medication Authorization for Overnight Field Trips which includes medication doctor orders, directions, delivery and guardian/ parent signature.*

****This form (and if student has medication needs Form F2 Medication Authorization for Overnight Field Trips) must be completed and returned to the school health office 5 days prior to departure of field trip.*****

In the event of an emergency, Emergency Medical Services will be called and student will be transferred to the nearest medical facility. I have completed this form to the best of my knowledge. I understand that ISD 166 staff and non-staff adult chaperoning personell may learn of my students health and medication information on a "need to know basis" for the safety and care of my student. ISD 166 staff and non-staff adult chaperoning personell will be trained in safe and correct medication administration and may be assigned this duty for my student while he or she is away. I understand that all adult responsible parties will act in good standing and will care for the health and medical needs of my child to the best of their ability. As such, I will not hold the school or those supervising the field trip responsible should injury, incident or injury. I give consent for my child/student to go on this field trip.

_____ _____

Signature of Guardian/Parent Date

This form has been reviewed by ISD 166 teaching staff:

(Signature) _____ (Date of Review) _____

If medical condition or medication was indicated, Health Office staff was notified (circle one): Yes or No

Health Office Staff Notified _____ Date Notified _____