STUDENT HEALTH & MEDICAL INFORMATION

STUDENT NAME_____ BIRTH DATE _____

ADDRESS _____ TELEPHONE_____

PHYSICIAN'S NAME _____ TELEPHONE_____

1. HEALTH HISTORY – PLEASE CHECK WHETHER YOUR CHILD HAS A HISTORY OF ANY OF THE FOLLOWING:

YES	NO	
___	___	Asthma
___	___	Bee/insect sting reactions
___	___	Convulsions
___	___	Diabetes
___	___	Ear infection
___	___	Heart Condition
___	___	Stomach upsets

2. Please list any food or medical allergies which might affect your child while on tour (i.e. pet allergies are not necessary here). List any dietary restrictions or allergies. Please note that although every attempt will be made to accommodate your child's special dietary needs, in some extreme cases, you may be asked to bring food supplements from home.

_____

_____

3. Are there any medical restrictions or limitations to your child's physical activities? If so, please specify.

_____

_____

4. Please list any medication your child must take during his/her participation in this excursion. Be specific about time and dosage. Medication should be given, in its original labeled prescription bottle, to the teacher in charge before departure.

MEDICATION	DOSAGE	PURPOSE	TIME(S)
_____	_____	_____	_____
_____	_____	_____	_____

4. When did your child have his last tetanus shot? _____

5. I hereby grant the Quebec trip chaperones permission to dispense to my child over the counter medications (circle any that apply): (acetaminophen/ibuprofen/other _____)

THIS HEALTH INFORMATION IS ACCURATE INSOFAR AS I KNOW. MY CHILD HAS PERMISSION TO ENGAGE IN ALL ACTIVITIES EXCEPT AS NOTED ABOVE.

***IN THE EVENT THAT I CANNOT BE REACHED IN AN EMERGENCY**, I AUTHORIZE MOUNTVIEW SCHOOL AND/OR ITS AGENTS TO OBTAIN THE PROPER TREATMENT TO ASSURE THE HEALTH AND WELL-BEING OF MY CHILD. THIS AUTHORIZATION SHALL ALSO EXTEND TO AND INCLUDE HOSPITALIZATION FOR FIRST AID WHERE/WHEN NECESSARY.*

_____

Parent/Guardian Signature

_____

Medical Insurance Provider

_____ _____

Medical Insurance Policy Number *Parent/Guardian Signature*

_____ _____

*Insurance Company's **800** Phone Number* *Date*