

****NOTE** – (Please fill this form out if we do not have one already on file, or you may fill it out again for this trip if you would like. If we have one on file and you don't want us to use it, please notify us about your decision.)**

FIELD TRIP HEALTH INFORMATION SHEET
(CHESTER SCHOOL DISTRICT)

Instructions: This form will be provided to the doctor or medical personnel to which you child is taken in the event of a medical emergency. Please complete **ALL** sections as accurately as possible.

If you have more than one child participating, complete one form per child.

Student's Name: _____ Nickname: _____

Home Address: _____

Home Phone #: _____ Date of Birth _____

Emergency Contacts:

Mother: _____ Daytime/Cell Phone: _____ Work Phone: _____

Father: _____ Daytime/Cell Phone: _____ Work Phone: _____

Alternate Contact: _____ Daytime/Cell Phone: _____ Work Phone: _____

Family Doctor: _____ Work Phone: _____ Alternate Phone: _____

General Information:

1. Food or drug allergies: _____

2. Other allergies: _____

3. Date of last tetanus shot: _____

4. Present medications: _____

5. Chronic medical problems: _____

6. Other items of concern: _____

PARENTAL AUTHORIZATION

In the case of medical emergency, in the event I/we cannot be reached, I/we authorize the agents of Chester School District, its agents, employees and other officers to procure and consent to any medical examination, diagnostic process or course of treatment, including hospital care, to be rendered to my/our child by or under the supervision of any duly licensed doctor, dentist, surgeon, or other health care provider.

_____ Date

_____ Parent or Guardian

_____ Date

_____ Parent or Guardian

_____ Health Insurance Company

_____ Policy #

_____ Group #

_____ ID #