

**WASHINGTON TOWNSHIP PUBLIC SCHOOLS  
SCHOOL TRIP/ACTIVITY MEDICAL INFORMATION**

Dear Parents:

We are happy that your son/daughter is planning to participate in Marching Band for the 2007-2008 School year. **Please complete this emergency health form and return by 7/18/07 to Mr. Casey Corigliano.**  
(date) (person/location)

**GENERAL INFORMATION (Please Type or Print)**

Student's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_  
(last) (first)

Address \_\_\_\_\_  
(street address) (town) (zip code)

**Parent/Guardian Contact Information:** Name \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

If your parent(s)/guardian(s) cannot be reached, and it is an **emergency**, we should call:

\_\_\_\_\_  
(Name) (Relationship) (Telephone Number)

**MEDICAL INFORMATION**

Has the child had any history of heart condition, asthma, epilepsy, allergies, diabetes, bleeding disorder or other health condition?

Yes \_\_\_ No \_\_\_ If yes, identify & explain condition.

Is the child allergic to anything such as foods, medicine, etc. Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_ What signs of an allergic reaction does your child have? \_\_\_\_\_ What does the child take for an allergic reaction? \_\_\_\_\_

Date of last Diphtheria Tetanus (D.T.) Booster \_\_\_\_\_ Does your child take any medication on a daily basis? Yes \_\_\_ No \_\_\_ If yes, please list \_\_\_\_\_ Will they be taking the medications listed on the trip? Yes \_\_\_ No \_\_\_

Family Physician \_\_\_\_\_ Address: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

**List all medications your child will be bringing on this trip, including over-the-counter medications:**

| DRUG | DOSE (mg and interval) | REASON TAKING DRUG |
|------|------------------------|--------------------|
|      |                        |                    |
|      |                        |                    |
|      |                        |                    |
|      |                        |                    |

I give permission for my child to self-administer the above medication, which will be in their original container(s) and they will bring only the amount needed for dates of each trip. I have reviewed with my child the proper medication administration indications and proper dosages. I also agree that the Washington Township School District and the trip chaperones shall incur no liability as a result of an injury arising from the self-administration of medication by my child. I give permission to share this medical information on a need-to-know basis.

In case of injury/illness/incident, I hereby authorize: (1) The school nurse and/or attending physician to provide the necessary emergency treatment; (2) The use of my insurance to cover medical treatment; and (3) Parent/Guardian agrees to be financially responsible for expenses incurred by Washington Township High School in the event their child does not have medical insurance coverage.

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **PRINT NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **PRINT NAME** \_\_\_\_\_ **OFFICE STAMP** \_\_\_\_\_

**A COPY OF YOUR CURRENT HEALTH INSURANCE CARD MUST BE ATTACHED TO THIS FORM**

This page may be duplicated to update health issues/ medication orders prior to the trip.

Additional forms can be obtained from the School Office.