

**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 2009-2010 School year. **Please complete this emergency health form and return by 7/15/09 to Mr. Casey Corigliano or Mrs. Shannon Schoch.**
(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.