Reset Print

Student Information
and Medical Form

Trip Information:
Destination of International-Travel: _____

Dates of Travel: _____ Travel Coordinator's Name: _____

Student Information:
Student's Name _____

Home Address _____

Parent/Guardian #1 Home Phone (____)_____Cell Phone (____)_____ Work (____)_____

Parent/Guardian #2 Home Phone (____)_____Cell Phone (____)_____ Work (____)_____

Health Insurance Provider: _____

Health Insurance Policy Number: _____

Primary Subscriber of Medical/Health Policy: _____

Student's Doctor: _____ Phone: (____) _____

Address: _____

Health History:
Please check any that apply and provide an explanation in the space below:

☐ Asthma ☐ Motion Sickness ☐ Hearing Loss ☐ Diabetes

☐ Constipation ☐ Convulsions ☐ Nose Bleeds ☐ Faints Easily

☐ Sleep Walking ☐ Wears Contacts ☐ Allergies ☐ Other

_____

Epi Pen: Yes ☐ No ☐ Date of Last Tetanus Shot: _____

Chronic Health Conditions and Significant Medical History: _____

Please return this form and medications in pharmacy labeled containers at least two weeks prior to your child's trip to: _____

_____
Signature