EDISON PUBLIC SCHOOLS
HEALTH INFORMATION FOR FIELD TRIPS

Please complete **ALL** sections of this form in **PEN ONLY.** **Trip Advior/Teacher:** _____
Student Name: _____ Student ID #: _____
Home Address: _____ Date of Birth: _____/_____/_____
HR/Grade: _____ Age: ___ Male: ___ Female: ___
Destination of Trip: _____ Date(s) of Trip: _____

Emergency Contact Person(s): *** Please make sure these contacts CAN BE REACHED THE DAY(S) OF THE TRIP.**
1. Mother/Guardian: _____ Contact Phone Number: _____
2. Father/Guardian: _____ Contact Phone Number: _____
3. Emergency Contact: _____ Contact Phone Number: _____
4. Emergency Contact: _____ Contact Phone Number: _____

*Does your child have any health-related condition or medication that may need special consideration during the field trip? ___ NO ___ YES (please specify) _____

*Has your child had any recent (past 6-12 months) injuries, illnesses, surgeries, or any updates in health history?
___ NO ___ YES (please specify) _____

*Is there any health-related condition or reason that your child may **not** participate fully in the field trip activities?
___ NO ___ YES (please explain) _____

***Is the Parent/Guardian available to chaperone for a medical condition or reason?** YES / NO (please circle)

***Please read the following information regarding MEDICATION on field trips. ALL MEDICATIONS (prescription and over-the-counter) require current physician order and parent permission on file. Medication MUST be in the original labeled container/packaging. Contact the school nurse for the district medication administration form.**

****Please select all that applies:**

____ No medication is needed
____ My child's school dose of _____ may be given by the nurse. In the event that a nurse is not available, the dose **MAY BE WITHHELD.**
____ I will serve as a **CHAPERONE** on this trip and dispense medication to my child.
____ My child will **SELF-ADMINISTER MEDICATION (Self-Administered of Medication & Parent/Guardian Authorization form must be on file)**
____ My child has **ASTHMA** and will self-carry an inhaler for this trip. **(An Asthma Action Plan with self-administered authorization must be on file)**
____ My child has a life-threatening allergy, as stated above. The nurse or delegate will carry and administer my child's epinephrine auto-injector in an emergency. **(Severe Allergy Emergency Treatment Plan must be on file)**
____ My child has a life-threatening allergy, as stated above. He/She will self-carry an epinephrine auto-injector for this trip. **(A severe Allergy Emergency Treatment Plan with self-administered authorization must be on file)**

PARENT/GUARDIAN AUTHORIZATION:
The above information is correct to the best of my knowledge, and my student can engage in all field trip activities unless noted above. In case of emergency and I can not be reached, I give permission to the physician or hospital selected by the school representative to secure proper treatment and medical care (e.g. medication, anesthesia, surgery, etc.) in case of emergency or as specified above for my student.

_____ _____
SIGNATURE OF PARENT/GUARDIAN **DATE**

nm: 9/23