

MEDICAL INFORMATION FORM AND MEDICAL PROXY

Student Name _____ Sex: _____ Age: _____ Grade: _____

Address: _____ City: _____ St. _____ Zip _____

Parent/Guardian Name: _____ Home Phone _____

Cell Phone: _____ Work Phone: _____

Name of Health Insurance: _____

Agreement Number: _____ Group Number: _____

Name of Subscriber: _____

Name of Employer: _____

Address: _____ City: _____ St. _____ Zip: _____ Phone: _____

EMERGENCY CONTACT INFORMATION-(MUST BE DIFFERENT FROM ABOVE)

Name: _____ Relationship to Student: _____

Home Phone: _____ Cell: _____ Work: _____

Is your child currently under the care of a Physician? YES NO (please circle one)

If yes, why? _____

Is your child currently taking any medications? YES NO (please circle one)

If yes, please name the medication and the physician name and number. _____

Please list all allergies: _____

Will your child be carrying any self-medication? If yes, please list: _____

Date of student's last tetanus shot _____

Any other medical concerns? _____

Can your child take any of the following if necessary? (Please circle all that apply)

Tylenol Advil Dramamine Antacids

MEDICAL PROXY

I give permission for _____ to be given medical treatment if necessary during the educational travel experience taking place on _____.

Signature _____ Printed Name _____