Jackson Public Schools Health Form
Jackson High School World Language Department Extended Trips/Camps

Student Name_________________________________ Sex_______ Date of Birth____________

Address____ Place of Birth______________

City____________________ Zip_________ Parent/Guardian Name______________________

Home Telephone___________________ Work (or other) Telephone _____________________ (If you will not at the above address during schedule trip/camp time, designate contact information on back of form)

Family Health Insurance Policy/Carrier ____

Policy/Group Number ___________________________________

Family Physician _________________________________Telephone ___________________

Please check if your child has any of the following problems (please explain on back of form):

____ Allergies or reactions ____ Heart trouble ____ Shortness of Breath
___ Hay Fever, asthma ____ Diabetes ____ Wears glasses/contacts
____ Eczema or rashes ____ Frequent cold, sore throats ____ Menstrual problems
____ Convulsions/Seizures ____ Urinary or Bowel trouble ____ Dental problems
____ Recent operation/injury
Date last tetanus shot________________________________
Allergy to medications____

(Indicate special conditions to be watched for, such as allergic reactions to insect stings or bites, fainting, etc.)

Medications child will be bringing____
*Dosages and Times____

(Please check in with the first aide parent at time of check-in for trip/camp regarding medications)

Please check medications your child may receive:
____ Ibuprofen for muscle aches
____Tylenol for headaches and fever
____ Tylenol Cold for congestion
____ Benedryal/Zyrtec for allergies/allergic reactions
____ Tums, Pepto Bismol, Pedialyte etc

_____ Food Allergies ____
_____ Dietary restrictions ____

I give permission for my child to attend this school sponsored trip/camp and he/she may participate in all program activities. I am aware of the details of the trip/camp and will contact the appropriate sponsor if I have any questions. Unless specifically indicated in writing, I give permission for my child to receive the above over-the-counter medications as indicated. In an emergency, assuming that my spouse or I cannot be reached, I hereby give permission to the licensed physician selected by the staff person in charge to hospitalize, secure proper treatment, anesthetize or to perform surgery for my child named on this form.

Signature of Parent/Guardian ____ Date_____________