UPPER MERION AREA SCHOOL DISTRICT
FIELD TRIP MEDICAL INFORMATION AND PERMISSION FORM

Date, hours and location of field trip_____

Supervising teacher(s)_____

Student needs for trip_____

The completed form to be returned to teacher by_____

I give permission for my son/daughter to participate in the field trip described above. In the event of an emergency, Upper Merion Area School District personnel may authorize emergency medical treatment for my son/daughter. I understand that medical information may be reviewed by the school nurse prior to the trip. On the date of the trip, medical information will be disclosed only to appropriate medical personnel in the event of an emergency.

Signature of parent/guardian_____ Date_____

Student Name_____ Grade_____

Address_____

City_____ State _____ Date of Birth_____

Father/guardian:_____

Telephone Numbers:_____
Home Work Cell

Mother/guardian:_____

Telephone numbers:_____
Home Work Cell

In case of emergency, if unable to reach parent, notify:

Name:_____ Relationship:_____

Telephone numbers:_____
Home Work Cell

List any allergies(bee stings, medication, food)_____

List any history of serious medical conditions_____

List any medications presently taken_____

Physician's name:_____ Phone number:_____

Dentist's Name:_____ Phone number:_____

Health Insurance:_____ Policy Number:_____

Distribution: White – Office Yellow – Teacher Pink – Nurse

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