Cherokee County School District

REQUIRED STUDENT HEALTH INFORMATION FOR OVERNIGHT FIELD TRIP

THIS FORM IS MANDATORY FOR ATTENDANCE

School_____ Date of Trip_____

Destination_____

Student _____ Date of Birth_____

Please complete the following.

1. Name of Insurance Carrier_____
   Policy Number_____

   ATTACH A PHOTOCOPY OF THE HEALTH INSURANCE CARD.

2. Physician's Name_____
   Phone number_____
3. Emergency Numbers
   a. Mother/Guardian _____

      Home_____ Work_____ Cell_____

   b. Father/Guardian _____

      Home_____ Work_____ Cell_____

   c. Other Contact: _____ Relationship_____

      Home_____ Work_____ Cell_____

4. Allergies: Please check Yes or No to each item. If Yes, please specify.

   a. Food Yes _____ No_____
   b. Medication Yes_____ No_____
   c. Insect Stings Yes_____ No_____
   d. Other Yes_____ No_____

   Symptoms of Reaction_____

   Treatment_____

5. ALL MEDICATIONS TO BE GIVEN ON THE TRIP WILL BE PROVIDED BY THE PARENT/GUARDIAN AND WILL BE GIVEN BY SCHOOL STAFF ONLY. Medications will be in the prescription container with correct directions on the label or in the original, sealed container if non-prescription. List below the medications your child may need on the trip.

   Medication _____ Time to be given _____

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6. Restrictions/Health Concerns_____

   _____

   I give my permission for the staff of Cherokee County School District to administer the medications listed above (furnished by me) and seek medical treatment if needed for my child during the overnight field trip.

Parent/Guardian Signature:_____ Date:_____