HS FORM #28

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

HEALTH INFORMATION FOR FIELD TRIPS

Student Name: _____ Social Security # (optional): _____
Home address: _____ Date of Birth: _____
Homeroom: _____ Grade: _____ Age: _____ Male: ___ Female: ___
Destination of Trip: _____ Date(s) of Trip: _____
Trip Advisor/Teacher: _____
Emergency Contact Person(s)*:
1. Mother/Guardian: _____ Home phone: _____
Work phone: _____ Beeper/Cell phone: _____
2. Father/Guardian: _____ Home phone: _____
Work phone: _____ Beeper/Cell phone: _____
3. Other Contact person: _____ Home phone: _____
Work phone: _____ Beeper/Cell phone: _____
4. Physician Name: _____ Phone: _____

** Please make sure these persons CAN BE REACHED THE DAY(S) OF THE TRIP.*

Does your student have Health Insurance? ___ Yes ___ No

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Is there any health-related condition or medication which may need special consideration during the field trip? ___ NO ___ YES (please specify below)
Condition/medication(s):
_____

- *If there is a significant health-related condition which may need special consideration during the field trip, please make every attempt to be a trip chaperone. If student's safety cannot be arranged and assured, student may not be able to attend.*
- *Students are allowed to self-administer asthma inhalers, injectable epinephrine, or other medication for a life-threatening condition providing there is physician and parent permission on file for the current school year. Contact the school nurse for appropriate district forms to be completed.*
- *ALL MEDICATIONS (prescription and over-the-counter) require current physician order and parent permission on file. Medication MUST be in original labeled container or packaging. Contact school nurse for district medication administration form.*
- *CONTACT THE SCHOOL NURSE IMMEDIATELY IF ANY HEALTH CONCERN.*

Is there any reason that your student may not participate fully in the field trip activities?
___ NO ___ YES (please specify below)
Explain limitation(s): _____

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 cannot 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

HEALTH HISTORY UPDATE:

Please check YES or NO for the following health information concerning your student. Be sure to include any recent (past 6-12 months) injuries, illnesses, or surgery that is in the student's health history which could influence their class trip activity participation or needs.

	Yes	No	Specifics
Allergy (environmental, food, medication etc.)	___	___	_____
Arthritis/joint or bone condition	___	___	_____
Asthma/Reactive Airway Disease	___	___	_____
Bleeding/blood disorder	___	___	_____
(eg: anemia, hemophilia, sickle cell disease, etc.)			
Communicable disease/condition or recent exposure	___	___	_____
(eg: strep, head lice, chicken pox, pink eye, impetigo, ringworm, etc.)			
Developmental condition/consideration	___	___	_____
(eg: ADHD, Down's Syndrome, Autism, brain injury, etc.)			
Diabetes	___	___	_____
Digestive/stomach condition	___	___	_____
Dental/orthodontic appliance or other prosthesis	___	___	_____
Eyeglasses/contacts/vision loss	___	___	_____
Fainting/lightheaded episodes/heat sensitivity	___	___	_____
Hearing loss	___	___	_____
Heart condition or chest pain with exercise	___	___	_____
High blood pressure	___	___	_____
Seizure disorder	___	___	_____
Immune system disorder	___	___	_____
(eg: mono, chronic fatigue syndrome, chemotherapy, etc.)			
Menstrual disorder/difficulties	___	___	_____
Significant fears/phobias	___	___	_____
Sleepwalking or sleep time difficulties	___	___	_____
Toileting considerations	___	___	_____
Orthopedic condition, recent injury, back pain	___	___	_____
Other (please specify)	_____		
Date of most recent tetanus shot, if known	_____		

Please specify any dietary needs:

___ Vegetarian ___ No milk/dairy ___ Food allergy ___ Other

** Some conditions above may require specific physician clearance to participate.

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