

**EDISON PUBLIC SCHOOLS  
HEALTH INFORMATION FOR FIELD TRIPS**

Please complete **ALL** sections of this form in **PEN ONLY**.

Student Name: \_\_\_\_\_ Student ID #: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 HR/Grade: \_\_\_\_\_ Age: \_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_  
 Destination of Trip: \_\_\_\_\_ Date(s) of Trip: \_\_\_\_\_

Emergency Contact Person(s): \* **Please make sure these contacts CAN BE REACHED THE DAY(S) OF THE TRIP.**

1. Mother/Guardian: _____	Contact Phone Number: _____
2. Father/Guardian: _____	Contact Phone Number: _____
3. Emergency Contact: _____	Contact Phone Number: _____
4. Emergency Contact: _____	Contact Phone Number: _____

\*Does your child have any health-related condition or medication that may need special consideration during the field trip?  NO  YES (please specify) \_\_\_\_\_

\*Has your child had any recent (past 6-12 months) injuries, illnesses, surgeries or any updates in health history?  NO  YES (please specify) \_\_\_\_\_

\*Is there any health-related condition or reason that your child may **not** participate fully in the field trip activities?  NO  YES (please explain) \_\_\_\_\_

\*Parent/Guardian available to chaperone for medical condition or reason? YES / NO (please circle)

**\*Please read the following information regarding MEDICATION on field trips. ALL MEDICATIONS (prescription and over-the-counter) require current physician order and parent permission on file. Medication MUST be in the original labeled container/packaging. Contact school nurse for district medication administration form.**

**\*\*Please check off the following:**

- No medication is needed
- My child's school dose of \_\_\_\_\_ may be given by the nurse. In the event that a nurse is not available, the dose **MAY BE WITHHELD.**
- I will serve as a **CHAPERONE** on this trip and dispense medication to my child.
- My child has **ASTHMA** and will self-carry an inhaler for this trip. **(Asthma Action Plan with self administered authorization must be on file)**
- My child has a life threatening allergy, stated above. The nurse or delegate will carry and administer my child's epinephrine auto injector in an emergency. **(Severe Allergy Emergency Treatment Plan must be on file)**
- My child has a life threatening allergy, stated above. He/She will self-carry an epinephrine auto injector for this trip. **(Severe Allergy Emergency Treatment Plan with self administered authorization must be on file)**

**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 can not 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