HEALTH HISTORY MEDICAL RELEASE

PART 1: **TO BE COMPLETED BY PARENT/CUSTODIAL GUARDIAN**

PARTICIPANT'S LAST NAME ____ FIRST ____ MIDDLE ____ BIRTH DATE ____

STREET ADDRESS ____ CITY ____ STATE ____ ZIP CODE ____

FATHER'S NAME ____ BUSINESS PHONE ( ) ____ CELL PHONE ( ) ____ HOME PHONE ( ) ____

MOTHER'S NAME ____ BUSINESS PHONE ( ) ____ CELL PHONE ( ) ____ HOME PHONE ( ) ____

If not available in an emergency please notify:

RELATIONSHIP ____ BUSINESS PHONE ( ) ____ CELL PHONE ( ) ____ HOME PHONE ( ) ____

PART 2: **HEALTH HISTORY TO BE COMPLETED BY PARENTS**

NO	YES	
☐	☐	**My child is currently taking medications:**
☐	☐	Med # 1 ____ Dosage ____ Reason ____
☐	☐	Med # 2 ____ Dosage ____ Reason ____
☐	☐	**My child has Medication Allergies (please list):** ____
☐	☐	**My child has Food Allergies:** ____
☐	☐	**My child has other Allergies:** ____ (Include insect stings, hay fever, asthma, etc.)
☐	☐	**My child is under the care of a physician for the following condition:** ____
☐	☐	**My child has medical conditions the school/chaperones should be aware of:** ____

Date of last Tetanus Immunization: ____

PART 3: **FAMILY HEALTH INSURANCE INFORMATION**

(Please be aware that few doctors will directly bill out of state patients.)

Carrier ____ Group # ____ Policy # ____

Carrier Address ____ Insured ____

Relationship to Insured ____ I.D. # ____

PART 4: **TO BE SIGNED BY PARENT/GUARDIAN**

(Must be signed for your child to participate on the field trip)

I hereby give permission to my child's sponsoring organization (i.e. school)/chaperones to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to my child's sponsoring organization/chaperones to arrange necessary related transportation for my child. In the event I can not be reached in an emergency, I hereby give permission to the physician selected by my child's sponsoring organization/chaperones to secure and administer treatment, including hospitalization, for the person named above. I understand that none of the tour company, the sponsoring organization or the chaperones are responsible for the quality of any such medical treatment.

SIGNATURE OF PARENT/GUARDIAN ____

PRINTED NAME ____ DATE ____