

# APPENDIX M TRIP MEDICAL

## MEDICAL INFORMATION FORM (TRIPS)

Student Name \_\_\_\_\_

Parents, fill out **all** sections of this form, date and sign.

Medical Plan # \_\_\_\_\_

Full Address \_\_\_\_\_  
 \_\_\_\_\_

### Health Statement

Please list **any ailments, disabilities or problems involving your child which might affect his/her participation.**

- asthma       bronchitis       epilepsy       nightmares  
 bed wetting       ear infection       heart disease       sinus       sleepwalking

allergies – explain \_\_\_\_\_

other – explain \_\_\_\_\_

Any medication required by the student which is to be administered by the trip supervisor must be provided to the supervisor and clearly labeled with the student's name, the name of the medication, what it is to be used for, how it is to be given, the quantity to be given and the times it is to be given. Only the amount of medication required for the duration of the trip should be provided.

Name of medicine	What it is to be used for	How it is to be given	Quantity to be given

By signing below, I am requesting that the trip supervisors administer these medications as directed above.

\_\_\_\_\_  
 Parent signature

\_\_\_\_\_  
 Date

### IN CASE OF EMERGENCY

I hereby request the physician selected by the trip supervisor to provide treatment for my child named above.

\_\_\_\_\_  
 Signature – Father

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature – Mother

\_\_\_\_\_  
 Date

### IN CASE PARENTS CANNOT BE REACHED IN AN EMERGENCY – CONTACT INFORMATION

Full Name of Contact	Ph# - home	Ph# - work	Ph# - cell
Relationship to Family			
Name of Family Doctor			Ph #