MEDICAL INFORMATION FORM

(Required for any student requiring medication or medical attention)

Child's Name: _____

Date of Birth: _____

Health Insurance Provider and # of Medical Plan: _____

_____

Doctor's Name & Phone #:_____

Parent's Contact Number: Cell:_____ **Work:** _____**Other:**_____

If parents cannot be reached in an emergency, please contact:

Name: _____**Phone #:** _____

LIST ANY AILMENTS, DISABILITIES OR PROBLEMS INVOLVING YOUR CHILD WHICH MIGHT AFFECT HIS/HER PARTICIPATION.

Asthma_____	Diabetes _____	Nightmares_____
Allergies_____	Ear Infection_____	Sinus_____
Bronchitis_____	Epilepsy_____	Sleepwalking _____
Bed Wetting_____	Heart Disease_____	Other _____

Information of which sponsors should be aware:

1. Unusual reactions or allergies to drugs.
2. Special care needed while on activity.
3. Special instructions to medical personnel if emergency care is needed.
4. Significant health problems of student.

All prescription and non-prescription medication to be administered by trained school personnel during the field study must have an Authorization to Administer Medication form signed by both the parent/guardian and the physician ordering the medication if not already on file in the school clinic. All medication must be received in the original container with current Rx label including student's name, dosage, and frequency of administration, physician's name, and expiration date of medication. All non-prescription medication in the possession of students at the middle and high school level not administered by school personnel must be in the original container and requires written permission from the parent to the school.

All medication and required documentation must be cleared through the **School Clinic** prior to the field study**.**

Name of Medicine: _____

What it is to be used for: _____

How it is to be given: _____Quantity to be given: _____ Time to be given: _____

Parent's Signature _____

IN CASE OF EMERGENCY: I hereby request the physician/emergency team selected by the supervisor provide treatment for my child named above.

Name: (Print) _____

Parent's Signature: _____ **Date:** _____