HEALTH HISTORY
FIELD TRIP PERMISSION FORM
2019-2020

Student Name (print) _____ D.O.B._____/_____/_____

Insurance Company _____Policy Number _____

HEALTH HISTORY:

Please (x) any of the following conditions your child has experienced and circle NO / YES:

____Hearing Problems Describe: _____

____Vision Problems Wears glasses? (circle) No / Yes Wears contacts? (circle) No / Yes

____Allergies List: _____

What happens?_____

Is EpiPen prescribed for allergies? (circle) No / Yes If yes, parent must provide EpiPen.

____Bee Sting Allergy What happens? _____

____Is EpiPen prescribed for bee stings? (circle) No / Yes If yes, parent must provide EpiPen.

____Asthma - Is an inhaler used? (circle) No / Yes How often? _____

List medications taken for asthma _____

Name of asthma doctor _____ Phone_____

____Diabetes - Name of diabetes doctor _____ Phone_____

____Seizures - What type? _____ Last seizure (date) _____

Medication taken _____

Name of seizure doctor _____ Phone_____

____Hospitalizations - For what? _____

____Episode of loss of consciousness (circle) No / Yes When? _____

____Bone/Joint problem or fracture? (circle) No / Yes Is a brace worn? (circle) No / Yes

What bone or joint and when?_____

List any recurrent medical problem or unusual illness of which you want the nurse to be aware.

_____

_____

List any activity restrictions _____

_____

_____ **MY CHILD IS HEALTHY AND HAS NO HEALTH PROBLEMS**

PERMISSION for over-the-counter medication during the school day and/or school related activities

I authorize the school nurse and Phonics Phactory staff to administer the following OTC medications at their discretion. PLEASE CHECK MEDICATIONS PERMITTED.

____Acetaminophen (Tylenol) _____Diphenhydramine HCL (Benadryl) _____Anti-itch skin creams

____Ibuprofen (Advil, Motrin) _____Antacids (Tums, Mylanta) _____Cough medicine/drops

Physician's name_____ Phone _____

Location of offices_____

Mother/Guardian (print) _____

Home Phone _____Cell Phone _____

Signature _____ Date _____

Father/Guardian (print) _____

Home Phone _____Cell Phone _____

Signature _____ Date _____

Neighbor or relative _____ Phone_____

PERMISSION FOR MEDICAL TREATMENT / FIELD TRIPS:

I *hereby consent to have my child,_____, participate in field trips supervised by the teaching staff away from the school grounds to local points of interest.*

I hereby authorize the Phonics Phactory to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary emergency medical and surgical care, in case I am not immediately available. Any qualified physician, called by the Phonics Phactory, may treat and do whatever is necessary for the health and well being of my child.

It is understood that a conscientious effort must be made to notify me (the parents) before such action will be taken. I also agree to accept responsibility for the cost of above medical services, and that any school insurance is secondary to my own primary insurance coverage.

Mother_____Date_____

Father_____Date_____

Legal Guardian_____Date_____

This form must have two signatures. If your child is in the custody of one parent, please indicate.