HOWARD COUNTY
PUBLIC SCHOOL SYSTEM

IFAS# 39502236 Form

EMERGENCY PROCEDURE/HEALTH INFORMATION for EXTENDED DAY, OVERNIGHT FIELD AND FOREIGN TRAVEL TRIPS

MUST BE COMPLETED BY PARENT FOR ANY STUDENT ATTENDING TRIP

STUDENT'S NAME _____ MALE____ FEMALE____
LAST NAME FIRST NAME MIDDLE INITIAL

SCHOOL _____ GRADE _____ DATE OF BIRTH _____

STREET ADDRESS _____

CITY _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

FAMILY PHYSICIAN _____ PHONE _____

PARENT/GUARDIAN NAME _____

EMERGENCY NOTIFICATION

(List in order of Notification - Parent/Guardian will be contacted first unless otherwise specified.)
MAJOR EMERGENCIES WILL BE TAKEN TO THE NEAREST HOSPITAL

NAME OF PERSON RELATIONSHIP PHONE NUMBER

NAME OF PERSON RELATIONSHIP PHONE NUMBER

HEALTH INFORMATION

(Please list & give dates if known)

Health conditions/operations:

Handicapping Conditions:

Allergies (medication, food, insects, etc.):

Describe the usual **symptoms/reactions:**

Medications (prescription and non-prescription):

If prescription or over-the-counter medication is to be taken, a separate written order from your physician specific to Medication Form/Physician's Order (IFAS# 39513035) is required. Refer to attached Medication/Treatment Order. MEDICATION MUST BE PROVIDED FROM HOME. There will not be a school nurse in attendance on this trip.

Does your child have any activity restrictions? Yes_____ No _____ If yes, please explain._____
Does your child have dietary restrictions? Yes_____ No _____ If so, what are restrictions?_____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

The information you provide will be handled in a confidential manner. Information provided on this form will be shared with staff as necessary to maintain your child's safety.

INSURANCE COMPANY _____ POLICY OR BINDER NUMBER _____

PERMISSION IS GRANTED FOR TREATMENT OF THE ABOVE NAMED PARTICIPANT BY A PHYSICIAN AND/OR HOSPITAL FOR ANY MEDICAL OR SURGICAL EMERGENCY.

PARENT/GUARDIAN SIGNATURE _____ DATE_____