

Extended Field Trip Medical Information

STUDENT INFORMATION		
Family Name	First name	Preferred name
Date of birth	Place of birth	Gender
MEDICAL INFORMATION pertinent to this specific trip		
Health insurance company		Health insurance no.
Height: cm	Weight: kg	Blood Type:
Our son/daughter currently suffers from:		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Ear infection
<input type="checkbox"/> Asthma	<input type="checkbox"/> malfunction	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Convulsion	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Migraine
<input type="checkbox"/> Nausea/sickness	<input type="checkbox"/> Problems with	<input type="checkbox"/> Sleeping disorder
<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> spinal column	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Sinusitis		
Allergies to medicines:		
Other allergies (food, insects, etc.):		
Special Diet	<input type="checkbox"/> Vegetarian	<input type="checkbox"/> No pork
	<input type="checkbox"/> Other:	
If your child is female, is there any information pertaining to menstrual periods that we should know?		
Operations in the last 10 weeks (please explain):		
Other conditions, not listed here, which require treatment or possible teacher attention?		
Will you allow your son/daughter to bring any non-prescription medication (e.g. tablets for headaches)?		
<input type="checkbox"/> Yes – please explain:		<input type="checkbox"/> No
Can your son/daughter carry and administer the medication him/herself or	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Should it be carried and administered by a supervising adult	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If 'Yes' to the second option, when should this medication be administered?		
Does a religious or other reason play a role concerning medical intervention? If yes, please explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
FAMILY'S DOCTOR INFORMATION		
Family name	First name	Phone no.
OTHER INFORMATION pertinent to this specific trip		
SIGNATURES		
We confirm that the medical information we provided is up-to-date.		
X _____		_____ Date
X _____		_____ Date
Signatures of (both) parent(s)/guardian(s)		Date