

LAST NAME:

Winslow Township High School Medical Information & Authorization Form

We are very happy that your son/daughter is planning to go on our Senior Class Trip to Orlando, Florida on April 1-6, 2020. The safety of all those going on the trip is very important to us. Therefore, in the event of illness or an accident (which we do not anticipate but could occur), please list two telephone contacts because doctors will not treat a minor without parental consent. In case of extreme emergency, where the parent cannot be contacted, a request is hereby made for the teacher in charge to act in "loco parentis" (in the parents' place).

GENERAL INFORMATION (Please Print All Information)

Student's Name (Please Print)	Date of Birth	Age
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Address

Parent's/Guardian's Name #1 (Please Print)	Cell Phone Number
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Parent's/Guardian's Name #2 (Please Print)	Cell Phone Number
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Additional Contact Name and Relationship to Student	Cell Phone Number
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MEDICAL INFORMATION

1. Allergies (please ✓ all those that apply to your child):

_____ Insect/bee allergy. Describe the reaction. _____

_____ Medication allergies. Please specify. _____

_____ Food allergies. Please specify. _____

2. Please list any other allergies

3. Health History

_____ Concussion/head injury _____ Diabetes _____ Asthma

_____ Epilepsy/seizures _____ Cardiac problems

Please indicate dates and describe any of the above health history problems:

LAST NAME:

4. Any past medical problems that an attending physician should know about:

5. List any medication to be taken by the student while on the trip:

6. My child carries a EPI-pen for self injection [] Yes [] No

7. Date of student's last tetanus shot: _____

8. Can your child swim? [] Yes [] No

9. Does your child have have health insurance at this time? [] Yes [] No

10. Name of Insurance Company: _____

11. Insurance Policy #: _____

12. Physician's Name: _____ Phone #: _____

**Only in cases of a medical emergency, where parental contact cannot be made,
I authorize the teacher in charge of the trip to act on my behalf as to medical administration.**

____/____/____
Date

Parent's/Guardian's Signature

***A photocopy of your health insurance card must
accompany this form.***

PHOTOCOPY BELOW IN THE SPACE PROVIDED