PRINT STUDENT'S LAST, FIRST NAME _____

Health History/Emergency Treatment Form

Clem Miller Environmental Education Center School Program

THIS FORM IS TO BE COMPLETED BY PARENT/GUARDIAN; NO DOCTOR'S APPOINTMENT IS NECESSARY.

Student's Name _____ Birth Date ___/___/___ Gender ___

Street Address _____ Home Phone ( ) _____

City, State, Zip _____

EMERGENCY CONTACTS

1. Custodial Parent or Guardian _____

   Day phone ( ) _____ Night phone ( ) _____Cell ( ) _____

2. Second Parent or Guardian or Local Relative or Close Family Friend _____

   Day phone ( ) _____ Night phone ( ) _____Cell ( ) _____

3. Local Relative or Close Family Friend _____

   Day phone ( ) _____ Night phone ( ) _____Cell ( ) _____

4. Local Relative or Close Family Friend _____

   Day phone ( ) _____ Night phone ( ) _____Cell ( ) _____

Insurance Carrier & Physician Information: Is the student covered by medical insurance? ☐ Yes ☐ No

Insurance Carrier or Plan Name _____ Group # _____

Family Physician _____ Phone ( ) _____

Required Parent/Guardian Authorization I certify that this health history is correct and complete. I authorize that my child named herein has my permission to engage in all activities except as noted. I, the undersigned parent/legal guardian, do hereby give permission to the medical personnel selected by the leader in charge or designee to order x-rays, tests, and treatment; to release any records necessary for treatment, referral, billing, or insurance purposes; and to provide or arrange any necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the health care providers selected by the leader in charge or designee to secure and administer treatment, including hospitalization, for my child. I give my permission for this completed form to be photocopied for official purposes.

(REQUIRED) Signature of Parent/Guardian* _____ **Date** _____

Printed Name of Parent/Guardian _____

I authorize the leader in charge or designee to administer (please check boxes)

☐ **Tylenol (or children's Tylenol, when appropriate)**

☐ **Benadryl (or children's Benadryl, when appropriate**

in the appropriate dosage for my child's age and weight, when deemed necessary for my child's health and well-being.

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____

Student's Comfort Level When Away from Home Overnight

My child has been overnight away from home _____ nights. Please describe: _____

My child has a tendency to experience homesickness □ yes □ no □ not sure

PRINT STUDENT'S LAST, FIRST NAME _____

MEDICATIONS

The leader in charge is permitted to administer only those medications, including prescription and over-the-counter medications, vitamins, supplements, medicated creams and/or lotions, with current labels attached and contained in original packaging. We are legally bound to administer prescriptions and dosages exactly as written.

Please list all medications including prescription and over-the-counter medications, vitamins, supplements, medicated creams and/or lotions you would like us to administer to your child during the field trip.

☐ My child will be taking NO medication(s) during the field trip.

☐ My child will be taking the following medication(s) during the field trip:

Med #1 _____ Dosage _____ Reason _____

Specific Dosage & Time _____

Med #2 _____ Dosage _____ Reason _____

Specific Dosage & Time _____

Med #3 _____ Dosage _____ Reason _____

Specific Dosage & Time _____

HEALTH HISTORY *circle yes or no* Please add additional pages, if necessary.

Yes No Anaphylactic Reaction (life-threatening allergic reaction to insect sting, food, chemical, etc)

Children diagnosed with severe allergic reaction/anaphylaxis must bring 2 allergic reaction kits (Epipen & Benadryl).

Trigger, date and severity of last reaction _____

☐ Check here if your child has been prescribed with and will be bringing 2 allergic reaction kits (Epipen & Benadryl).

Yes No Asthma

Trigger(s) and date of last attack _____

☐ Check here if your child has been prescribed with and will be bringing 2 asthma rescue inhalers.

Yes No Heart Condition Details _____

Yes No Diabetes Details _____

Yes No Epilepsy Date and severity of last episode _____

Yes No Frequent Severe Headaches, Nose Bleeds, Vomiting or Fainting

Date and severity of last episode _____

Yes No Difficulties with any of the following: □ Mobility □ Speech □ Hearing □ Vision □ Bedwetting

Details _____

_____

ALLERGIES List all known.

Allergen Describe reaction and management of reaction.

_____ _____

_____ _____

_____ _____

Year of most recent tetanus shot _____ If date is unknown, is tetanus immunization current? ☐ Yes ☐ No

Activity Limitations

Describe any activity restriction(s) your child will require _____

_____

Dietary Restrictions

My child is not permitted to eat ☐ Red Meat ☐ Pork ☐ Poultry ☐ Seafood ☐ Eggs ☐ Dairy products ☐ Other

Details _____

☐ My child is a picky eater. Details _____

Please provide any additional information about your child's overall physical, emotional and/or behavioral tendencies that would assist us in caring for him/her _____

_____

_____

_____