AUSTINTOWN FITCH BAND 2014/2015

FIELD TRIP MEDICAL FORM School Year

STUDENT INFORMATION

Student Last Name	First	Date of Birth	Student Cell	Grade

Student Address	Student Email

Father/Guardian's Name	Phone Number	Email Address
Address:	Home: Cell:	

Mother/Guardian's Name	Phone Number	Email Address
Address:	Home: Cell:	

EMERGENCY CONTACT	Phone Number	Relation to Student
	Home: Cell:	

MEDICAL INFORMATION

Chronic Illness or Physical Disabilities	List ALL Allergies	List Reactions to Allergies

LIST ALL MEDICATIONS (Include Prescription and Non-Prescription)

Please list any special instructions for your child in case of illness or injury:

INSURANCE INFORMATION

Please provide a copy of Insurance Identification Card and/or Prescription Identification Card

Insurance Company:	Policy Number:
Insurance Company Address:	Insurance Company Phone:

In case of severe illness or injury to my child, after reasonable attempts to contact me have been unsuccessful, I give my consent for the administration deemed necessary by my personal physician Dr.____________________, phone number _______________ or in the event the designated physician is unavailable, by any other licensed physician or the transfer of the student to my preferred hospital _______________________ or any hospital reasonably accessible if out of town.

Signature of Parent/Guardian	Date Signed: