# **HEALTH HISTORY MEDICAL RELEASE**

**PART 1:** **TO BE COMPLETED BY PARENT/CUSTODIAL GUARDIAN**

PARTICIPANT'S LAST NAME | FIRST | MIDDLE | BIRTH DATE

STREET ADDRESS | CITY | STATE | ZIP CODE

FATHER'S NAME | BUSINESS PHONE ( ) | CELL PHONE ( ) | HOME PHONE ( )

MOTHER'S NAME | BUSINESS PHONE ( ) | CELL PHONE ( ) | HOME PHONE ( )

**If not available in an emergency please notify:**

RELATIONSHIP | BUSINESS PHONE ( ) | CELL PHONE ( ) | HOME PHONE ( )

**PART 2:** **HEALTH HISTORY TO BE COMPLETED BY PARENTS**

NO YES

☐ ☐ **My child is currently taking medications:**

☐ ☐ Med # 1 _____ Dosage _____ Reason _____

☐ ☐ Med # 2 _____ Dosage _____ Reason _____

☐ ☐ **My child has Medication Allergies (please list):** _____

☐ ☐ **My child has Food Allergies:** _____

☐ ☐ **My child has other Allergies:** _____
(Include insect stings, hay fever, asthma, etc.)

☐ ☐ **My child is under the care of a physician for the following condition:** _____

_____

☐ ☐ **My child has medical conditions the school/chaperones should be aware of:** _____

_____

Date of last Tetanus Immunization: _____

**PART 3:** **FAMILY HEALTH INSURANCE INFORMATION**
(Please be aware that few doctors will directly bill out of state patients.)

Carrier _____ Group # _____ Policy # _____

Carrier Address _____ Insured _____

Relationship to Insured _____ I.D. # _____

**PART 4:** **TO BE SIGNED BY PARENT/GUARDIAN**
**(Must be signed for your child to participate on the field trip)**

I hereby give permission to my child's sponsoring organization (i.e. school)/chaperones to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to my child's sponsoring organization/chaperones to arrange necessary related transportation for my child. In the event I can not be reached in an emergency, I hereby give permission to the physician selected by my child's sponsoring organization/chaperones to secure and administer treatment, including hospitalization, for the person named above. I understand that none of the tour company, the sponsoring organization or the chaperones are responsible for the quality of any such medical treatment.

_____
SIGNATURE OF PARENT/GUARDIAN

_____ _____
PRINTED NAME DATE