FIELD TRIP MEDICAL FORM
FOR OUTDOOR, OVERNIGHT AND OUT OF PROVINCE TRIPS

Name of Student ____ Grade ________________ Division __________

Care Card Personal Health No.___________________________________ Date of Birth _______________________________

Family Doctor ____ Phone ____________________________________

Name of Parent/ Legal Guardian ____

Address ____

Home Phone ________________________________ Business Phone _____________________________

In case of emergency contact Parents(s)/Legal Guardian(s) or

Name ____ Phone ____________________________

Please note any health problems, physical handicap, emotional difficulty, behaviour problem, or other factors which may limit full participation in this program. Use back of sheet if necessary.

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Has the student had a previous injury which would require special first aid treatment should another injury occur? Explain _

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The student has received the regular immunization program administered in B.C. for diphtheria, pertussis & tetanus (DPT; tetanus and diphtheria (Td); polio; measles, mumps & rubella (MMR).
Yes No (circle) If no, please explain ____

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Contact Lenses Yes No (circle)

Child is subject to

( ) asthma	( ) ear ache	( ) fainting	( ) tonsillitis
( ) eye infection	( ) sensitive skin	( ) sinus problems	( ) seizures
( ) nightmares	( ) bronchitis	( ) high blood pressure	( ) nosebleeds
( ) headache	( ) bed wetting	( ) kidney problems	( ) dizziness
( ) frequent colds	( ) dislocations	( ) motion sickness	( ) sprains
( ) pulled muscles	( ) sleep walking	( ) severe allergies (describe below)	( ) other (describe below)

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Medications will only be administered in accordance with the District Policy No. 7012 Administration of Medication.

In case of emergency, I hereby give permission to the physician selected by the supervisor(s) to provide necessary treatment for my child.

Parent/Legal Guardian Signature _______________________________________ Date _______________

Special Dietary Requirements:

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