

EMERGENCY FORM

Student's Name _____

Parent _____

Parent _____

Day Phone _____

Day Phone _____

Evening Phone _____

Evening Phone _____

Cell Phone _____

Cell Phone _____

In case of emergency, illness or accident to the student named above, the advisors will make every effort to contact the parent(s) first. Please list additional contacts below.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Who is your child's doctor?

Name _____ Phone _____ Specialty _____

Health/Accident Insurance Company _____

Policy # _____

Does your child have any allergies to bees, *foods, or medications? No ____ Yes ____

Specify _____

Does your child take medication that needs to be administered while on the trip?

Medication _____ Dosage _____

***Prescription medication needs to be in original container with child's name on label and instructions – Please note if the medication needs to be refrigerated.**

Your students chaperone will be responsible for holding and administering the meds.

Can your child take any over the counter medication for headaches, etc. Yes ____ No ____

If so, what and how much _____

No over the counter medication should be packed with your child's belongings – We will provide anything that is necessary.

Are there any other concerns that we should know about? (list on the back)

*** Please let us know if you student has a food restrictions or needs a special diet or accommodations as soon as possible.**

Parent Signature

Date

