

# MEDICAL TREATMENT FORM

## MEDICAL FORM – THIS COMPLETED SIDE WORTH ONE TEST GRADE

If in the judgment of any representative of the school or of any adult member of this trip, the above student should need any necessary medical treatment as a result of any injury or sickness, I do hereby authorize school representatives to consent to all necessary medical treatment. I understand that school representatives will make every reasonable attempt to contact me before consenting to medical care for the above named student unless, because of the need to obtain emergency medical care, such attempts jeopardize the health of the above student. I agree to be responsible for all expenses for such medical care (unless otherwise covered by school or student insurance). This authorization to consent to medical treatment is effective at any time that the above student is in the custody and/or control of school representatives and/or at any time that the student is participating in this tour.

Student's PRINTED Full Name \_\_\_\_\_ Sex: M F Age: \_\_\_\_\_

- |  | YES   | NO    |
|--|-------|-------|
| 1. During the past 12 months:  |       |       |
| a. Was he/she hospitalized? .....  | _____ | _____ |
| b. Did he/she have any injuries requiring medical attention? .....   | _____ | _____ |
| c. Did he/she have any serious illness? .....  | _____ | _____ |
| 2. Does he/she take any medication regularly? .....  | _____ | _____ |
| 3. Do you know of any reason why there should be any limits on this student's activities on this trip? ..... | _____ | _____ |
| 4. Has he/she ever had a concussion or been "knocked out"? .....   | _____ | _____ |
| 5. Is he/she under a doctor's care? .....  | _____ | _____ |
| 6. Has he/she ever had a convulsion? .....   | _____ | _____ |
| 7. Is he/she missing any paired organ (eye, kidney)? .....   | _____ | _____ |
| 8. Are there any health problems that we should know about? .....  | _____ | _____ |
| 9. Any known allergies to medication? .....  | _____ | _____ |
| 10. Are there any religious or personal limitations to the health care given to this student? .....          | _____ | _____ |

If the answer to any of the above questions is **YES**, please give complete details below: (Attach sheet if needed)

\_\_\_\_\_

\_\_\_\_\_

Are you covered by hospitalization insurance? ..... YES \_\_\_\_\_ NO \_\_\_\_\_

Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Policy carried through work \_\_\_\_\_

Individual policy \_\_\_\_\_

Name and Address of place to mail claim form:

\_\_\_\_\_

Please give the name and phone of the nearest responsible party should we not be able to contact you .....

_____	_____	_____	_____
name	phone	name	phone

Family Doctor : \_\_\_\_\_ Home Phone: \_\_\_\_\_ Office: \_\_\_\_\_

\_\_\_\_\_

Parent Signature

\_\_\_\_\_

Parent Signature

Address: \_\_\_\_\_

City/Zip: \_\_\_\_\_

HOME PHONE : \_\_\_\_\_ EMERGENCY PHONE: \_\_\_\_\_

MOTHER WORK (CELL): \_\_\_\_\_ FATHER WORK (CELL): \_\_\_\_\_

***DO NOT FORGET TO COMPLETE AND SIGN BOTH SIDES***