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 <u>YES</u>, 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): ____________________________

<u>DO NOT FORGET TO COMPLETE AND SIGN BOTH SIDES</u>