

RESIDENTIAL HEALTH INFORMATION FORM



Dates of Trip \_\_\_\_\_

TO BE COMPLETED BY STUDENT'S PARENT OR GUARDIAN

NAME OF STUDENT: \_\_\_\_\_ SCHOOL DISTRICT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_

\_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_

NAME OF PARENT/GUARDIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ CELL PHONE #: (\_\_\_\_) \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_

NAMES AND PHONE NUMBERS OF TWO ADULTS WE CAN CONTACT IN THE EVENT YOU CANNOT BE REACHED:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_ CELL PHONE #: (\_\_\_\_) \_\_\_\_\_

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_ CELL PHONE #: (\_\_\_\_) \_\_\_\_\_

NAME OF FAMILY DOCTOR: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_

HEALTH INSURANCE CARRIER: \_\_\_\_\_ POLICY #: \_\_\_\_\_

DO YOU KNOW OF ANY HEALTH FACTOR THAT MAKES IT ADVISABLE FOR THE STUDENT TO FOLLOW A LIMITED PROGRAM OF PHYSICAL ACTIVITY? \_\_\_\_\_ IF SO, PLEASE DESCRIBE AND STATE LIMITATIONS.

**The student herein described has my permission to engage in all prescribed activities except as noted by me and/or the student's physician. In the event I cannot be reached in an emergency, I hereby give my permission to the physician, selected by the teacher in charge, to provide first aid treatment as needed.**

**SIGNATURE** \_\_\_\_\_  
Parent or Legal Guardian

**DATE** \_\_\_\_\_

RESIDENTIAL HEALTH INFORMATION FORM



TO BE COMPLETED BY NURSE OR PHYSICIAN

Name of Student: \_\_\_\_\_ School District \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_ Student SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

1. Date of most recent immunization:

tetanus \_\_\_\_/\_\_\_\_/\_\_\_\_ diphtheria \_\_\_\_/\_\_\_\_/\_\_\_\_ mumps \_\_\_\_/\_\_\_\_/\_\_\_\_ hepatitis b \_\_\_\_/\_\_\_\_/\_\_\_\_

measles \_\_\_\_/\_\_\_\_/\_\_\_\_ rubella \_\_\_\_/\_\_\_\_/\_\_\_\_ poliomyelitis \_\_\_\_/\_\_\_\_/\_\_\_\_

haemophilus influenza b \_\_\_\_/\_\_\_\_/\_\_\_\_ varicella (chicken pox) \_\_\_\_/\_\_\_\_/\_\_\_\_

2. List any health conditions, such as heart disease, diabetes, epilepsy, asthma or any chronic condition, etc.

\_\_\_\_\_

3. Does the student carry an inhaler? \_\_\_\_\_

4. Is there any condition the student has that requires medication? \_\_\_\_\_ If so, what is the condition and the treatment for it? \_\_\_\_\_

If medication needs to be administered, a doctor's note AND parent/guardian's note must be attached to this health form indicating the medication(s) and the instructions regarding dose and frequency.

PRESCRIPTION MEDICATION MUST BE SENT IN ORIGINAL PHARMACY CONTAINERS.

5. Allergies: If "yes", please indicate type and symptoms.

Y/N

Foods? \_\_\_\_\_

Insect stings? \_\_\_\_\_

Medications? \_\_\_\_\_

Other? \_\_\_\_\_

What treatment does the student receive for the allergic reaction(s)? \_\_\_\_\_

6. Has student been exposed to any communicable diseases in the past 21 days? \_\_\_\_\_

If so, please indicate disease(s). \_\_\_\_\_

7. Do you know of any health factor that makes it advisable for student to follow a limited program of physical activity?

\_\_\_\_\_ If so, please describe and state limitations. \_\_\_\_\_

8. Does the student wear glasses? \_\_\_\_\_ Contact lenses? \_\_\_\_\_

9. Dietary restrictions, if any: \_\_\_\_\_

DR  
RN  
LPN

SIGNATURE \_\_\_\_\_  
Physician or Nurse

DATE \_\_\_\_\_