

**Clearview Regional High School  
Overnight Field Trip Emergency Medical Form**

*(Please fill out both sides of the form. Please attach a recent photo and copy of current insurance card. The form must be signed by a parent on Page 2)*

Student Name: \_\_\_\_\_

Birth Date \_\_\_\_\_

Grade \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Eye Color \_\_\_\_\_

Hair Color \_\_\_\_\_

Father's Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Father's Address \_\_\_\_\_

Work Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Mother's Address \_\_\_\_\_

Work Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_

**STUDENT'S CELL PHONE** \_\_\_\_\_

**The student must present an original insurance card to receive medical treatment at any clinic.**

Health Ins. Co. \_\_\_\_\_

Policy No. \_\_\_\_\_

Prescription Ins. Co. \_\_\_\_\_

Policy No. \_\_\_\_\_

Health Ins. Co. Phone # \_\_\_\_\_

Prescription Co. Phone # \_\_\_\_\_

Family Physician \_\_\_\_\_

Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone or Cell \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone or Cell \_\_\_\_\_

Primary Cardholder's Date of Birth \_\_\_\_\_

List any illnesses such as diabetes, epilepsy, asthma, etc.	List allergies to medications, insects or food and provide a physician's order for Benadryl or epipen if necessary.	Please note any concerns that chaperones should be aware.

**Please turn form over**

**N.J. state law requires your doctor to sign this form if your student is taking prescription or over-the-counter drugs on the trip (i.e., Motrin, Tylenol, Advil, etc.). Birth control pills do not need to be listed/reported to the school nurse. This child is knowledgeable about his/her medication and may self medicate.**

Drug	Dose	Reason	Side Effects

\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
Date **Physician's Printed Name** **Physician's (Signature)** **Physician's Phone #**

**PLEASE READ AND SIGN BELOW EVEN IF YOUR STUDENT IS NOT TAKING MEDS ON TRIP**

- 1. I grant permission for my child to self-administer medication on the trip as instructed by our physician.
- 2. I agree that the Clearview Regional school district and the chaperones shall incur no liability as a result of any injury due to my child's self administration of medication.
- 3. I agree to the use of my insurance to cover any medical treatment.
- 4. I grant permission to share this information on a need to know basis.
- 5. I agree to be responsible for all medical expenses incurred in the event I do not have insurance.

\_\_\_\_\_ \_\_\_\_\_  
Date **Parent/Guardian Signature**

Glue copy of current photo

Glue copy of medical insurance card  
**(student will carry original card)**

