

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

(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 _____

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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 _____

Cardholder's Date of Birth _____

List any illnesses such as diabetes, epilepsy, asthma, etc.	List allergies to medications, insects or food. Please provide Physician's Order.	Please note any concerns of which the chaperones should be aware.

Please turn form over

N.J. state law requires your doctor to sign this form and list all prescription or over-the-counter drugs that the student will be taking on the trip. Birth control pills do not need to be listed/reported to the school nurse.

Drug	Dose	Reason	Side Effects

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

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 authorize the school nurse and/or any physician to provide emergency treatment.
4. I agree to the use of my insurance to cover any medical treatment.
5. I grant permission to share this information on a need to know basis.
6. 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)