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 _____

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 <u>all prescription or over-the-counter drugs</u> 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)