

GISD SPECIAL SITUATIONS STUDENT MEDICAL INFORMATION FOR TRIPS

Event: ALL CHOIR TRIPS School: Today's Date

Student Name: Birthdate:

Home Phone: Social Security #: Gender: male female

Current Address:

Father's Name: Street/P.O.Box City State Zip Home Phone: Work: Cell Phone

Mother's Name: Home Phone: Work: Cell Phone

Emergency Contact: Phones:

Health Insurance Company: Member Name:

Member I.D. # Group # Policy #:

Please list your preferred provider (Clinic, Doctor, HMO, etc.) List the provider's name, address, and phone number.

Please indicate medical alerts such as allergies, contact lenses, chronic illness such as Asthma, Diabetes, etc.

STUDENT HEALTH HISTORY AND RECORD

NAME: AGE: GRADE: DATE:

ADDRESS: PHONE:

HEALTH HISTORY

Please list any allergies to medication, food, or other allergens, and type or reaction:

Does student have any chronic health conditions? Yes No Date: Please List

Has student ever been hospitalized? Yes No Date: Reason:

Does student take any medications on a regular basis? Yes No Please list medication, dose, and times taken, and reason:

Are you concerned about any health concerns for the student at this time? Yes No

What are they?

Parent Signature: Date

MEDICATION PERMISSION

I give my permission for GISD staff, or the nurse on duty, to administer the following medications while on any band trip. I understand that no other medications will be made available or administered to my child by GISD staff on any band trip. All medications will be brought in original containers and all prescription medications will be brought in a pharmacist labeled bottle.

Name of medication	Strength of medication	Dose	Frequency	Reason for medication

Parent's Signature: _____ Date: _____

IMPORTANT INSURANCE NOTICE

Catastrophic Health Insurance is available through the Georgetown ISD. This is especially recommended for any students involved in high-risk activities like athletics or gymnastics. It is also recommended that students have personal health insurance.

RELEASEES AND WAIVERS

Signify your approval by writing your initials in the space before the statement(s) and signing below.

- ____ 1. In the event of an injury or illness to the above named student, I hereby authorize a representative of GISD to secure emergency medical treatment for the above named student from any healthcare provider.
- ____ 2. I understand that I will be financially responsible either with personal health insurance or other means, for medical treatment needed by my child.
- ____ 3. I certify that the information provided on this form is true and correct to the best of my knowledge.
- ____ 4. I hereby authorize the release of medical records and information as well as medical insurance information to the healthcare providers as needed for the treatment of injuries and illness to my child.
- ____ 5. I hereby authorize GISD staff, or nurse on duty, to administer the medications listed on this page of the document. I understand that the GISD will not provide medications for my child on this trip. I release from liability GISD, its staff, and nurses for any medication reactions or medication allergy that my child experiences.
- ____ 6. I hereby agree to bring this information up to date, as the need arises, before any band trip that might require medical attention.

Parent's Signature _____ Date: _____

Proof of I.D. _____ Expiration Date: _____