



FIELD TRIP MEDICAL FORM
FOR OUTDOOR, OVERNIGHT AND OUT OF PROVINCE TRIPS

Name of Student _____ Grade _____ Division _____
Care Card Personal Health No. _____ Date of Birth _____
Family Doctor _____ Phone _____
Name of Parent/ Legal Guardian _____
Address _____
Home Phone _____ Business Phone _____
In case of emergency contact Parents(s)/Legal Guardian(s) or
Name _____ Phone _____

Please note any health problems, physical handicap, emotional difficulty, behaviour problem, or other factors which may limit full participation in this program. Use back of sheet if necessary.

Has the student had a previous injury which would require special first aid treatment should another injury occur? Explain _

The student has received the regular immunization program administered in B.C. for diphtheria, pertussis & tetanus (DPT; tetanus and diphtheria (Td); polio; measles, mumps & rubella (MMR).

Yes No (circle) If no, please explain _____

Contact Lenses Yes No (circle)

Child is subject to

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear ache | <input type="checkbox"/> fainting | <input type="checkbox"/> tonsillitis |
| <input type="checkbox"/> eye infection | <input type="checkbox"/> sensitive skin | <input type="checkbox"/> sinus problems | <input type="checkbox"/> seizures |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> bronchitis | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> nosebleeds |
| <input type="checkbox"/> headache | <input type="checkbox"/> bed wetting | <input type="checkbox"/> kidney problems | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> frequent colds | <input type="checkbox"/> dislocations | <input type="checkbox"/> motion sickness | <input type="checkbox"/> sprains |
| <input type="checkbox"/> pulled muscles | <input type="checkbox"/> sleep walking | <input type="checkbox"/> severe allergies (describe below) <input type="checkbox"/> other (describe below) | |

Medications will only be administered in accordance with the District Policy No. 7012 Administration of Medication.

In case of emergency, I hereby give permission to the physician selected by the supervisor(s) to provide necessary treatment for my child.

Parent/Legal Guardian Signature _____ Date _____