RIVER VALLEY SCHOOL DISTRICT

660 West Daley Street ≈ Spring Green, Wisconsin 53588 ≈ Phone: 608-588-2551

352 - Exhibit 1

Student Health Information Form for Overnight School Trips

Student's Name: _____ Birth Date: _____ Grade: _____

Date(s) of overnight school trip: _____ Destination: _____

Student's Current Health Status

Please list all of student's health conditions including allergies: _____

Is your child currently under medical care: ☐ Yes ☐ No

Does your child currently have any physical restrictions: ☐ Yes ☐ No

Does your child currently have any dietary restrictions: ☐ Yes ☐ No

If yes to any of the above, please explain: _____

Other Concerns: _____

Medication

Will your child require medication(s) while on the overnight school trip: ☐ Yes ☐ No

If yes, please list: _____

If medication/dosage/time is different than presently prescribed for school, additional forms will be needed. Please include physicians order form for all prescription medication to be administered.

Emergency Contact Information

Name: _____ Relation: _____ Phone (H): _____ (W): _____

Name: _____ Relation: _____ Phone (H): _____ (W): _____

Name of Doctor: _____ Phone: _____

Preferred Hospital: _____

Health Insurance Carrier: _____ Policy # _____

I consent for emergency treatment of my child, if needed, if I or the other designated emergency contact cannot be reached. I hereby authorize the designated River Valley school staff member to contact the above named physician or, if not available, an alternate physician or emergency medical services. I understand that the school does not provide accident insurance for students. I have provided up-to-date and accurate health information as listed above, and I give my permission to share the information, with the appropriate school and medical personnel.

Signature of Parent or Guardian: _____ **Date:** _____

APPROVED: November 18, 2010
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