

## RIVER VALLEY SCHOOL DISTRICT

660 West Daley Street ≈

Spring Green, Wisconsin 53588 ≈ Phone: 608-588-2551

352 - Exhibit 1

Student's Current Health Status  Please list all of student's health conditions including allergies:	Date(s) of Field-overnight school trip:	Student Health Information Form for Overnight School Field Trips				
Please list all of student's health conditions including allergies:	Student's Current Health Status  Please list all of student's health conditions including allergies:	Student's Name:		Birth Date:	Grade:	
Please list all of student's health conditions including allergies:	Please list all of student's health conditions including allergies:					
Does your child currently have any physical restrictions:    Yes	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:					
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):	Does your child currently have any physical restrictions:	Please list all of student's he	ealth conditions including aller	gies:		
Does your child currently have any dietary restrictions:	Does your child currently have any dietary restrictions:	Is your child currently under	medical care: ☐ 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 needlease include physicians order form for all prescription medication to be administered.  Emergency Contact Information  Name:  Phone (H):  (W):  Name:  Name:  Phone (H):  (W):  Name:  Phone (H):  (W):  Name:  Phone:  Phone:  Name:  Phone:  Phone:  Name:  Phone:  Ph	Does your child currently ha	ινe any physical restrictions: Γ	] 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 needlease include physicians order form for all prescription medication to be administered.  Emergency Contact Information  Name:  Phone (H):  (W):  Name:  Name:  Phone (H):  (W):  Name:  Phone (H):  (W):  Name:  Phone:  Phone:  Name:  Phone:  Phone:  Name:  Phone:  Ph	Does your child currently ha	ive any dietary restrictions: □	Yes □ No		
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:  W:  Wes  No  No  Relation:  Phone (H):  Phone (H):  W:  No  No  Relation:  Rela	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 not please include physicians order form for all prescription medication to be administered.  Emergency Contact Information  Name:  Relation:  Phone (H):  Name:  Relation:  Phone (H):  Phone:  Ph	If yes to any of the above, p	lease explain:			
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If yes, please list:	If yes, please list:  If medication/dosage/time is different than presently prescribed for school, additional forms will be not please include physicians order form for all prescription medication to be administered.  Emergency Contact Information  Name: Relation: Phone (H): (W): Phone (H): (W): Phone:	<u>Medication</u>				
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): (W): Name: Relation: Phone (H): (W): (W): Name: Relation: Phone (H): (W):	If medication/dosage/time is different than presently prescribed for school, additional forms will be not please include physicians order form for all prescription medication to be administered.  Emergency Contact Information  Name: Relation: Phone (H): (W):  Name of Doctor: Phone: Phone: Phone:	Will your child require medic	cation(s) while on the overnigh	nt school trip: ☐ Yes ☐ No		
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):	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):	If yes, please list:				
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Name:	Name:					
Name: Relation: Phone (H): (W):	Name:       Phone (H):       (W):         Name of Doctor:       Phone:	Emergency Contact Inforr	nation			
	Name of Doctor: Phone:	Name:	Relation:	Phone (H):	(W):	
Name of Doctor: Phone:		Name:	Relation:	Phone (H):	(W):	
		Name of Doctor:		Phone:		

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 <u>does not</u> 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:
ignature of Parent or Guardian:	 Date:

APPROVED: November 18, 2010

REVIEWED: July 16, 2015