

DATE:

2009 Florida Trip Permission Slip –February 23 – 27, 2009

Please type or print the information requested below. Answer ALL questions even if the answer is no or none.

Complete one form for each child that will be going on the trip.

Name of Student _____ Date of birth _____ Sex: M F

Grade ___ Home Address _____ Town _____ Phone _____

Parent/Guardian Names _____

Health Insurance Company _____ Policy Number _____

In case of emergency Notify (Name) _____

Primary Telephone Contact: _____ Home _____ Work _____ Cell _____

Secondary Telephone Contact: _____ Home _____ Work _____ Cell _____

Primary Care Physician (PCP) Name _____

PCP Phone: Office _____ Cell _____ Hospital Affiliation: _____

Allergies (Include explanation): Is Child prescribed an EPI-PEN? YES NO or INHALER? YES NO

Animal _____

Food _____

Insect stings, bites. _____

Drugs, Medication _____

Other (Latex, Environmental, etc.) _____

Does your child have a history of any of the following?

- Asthma Bronchitis Respiratory Illness Convulsions Seizures Dizziness Fainting Spells
- Diabetes Hyperactivity Motion Sickness Kidney/Bladder Problems Stomach/Intestinal Problem
- Sunstroke/Sunburn Heart Problems High Blood Pressure Abnormal Heart Rate Hepatitis
- Eating Disorders Depression Pneumo-Thorax Other (Please Specify Below)

Do you authorize dispensing of the following Over the Counter Medications?

- Aspirin Tylenol Ibuprofen (Advil/Motrin) Benadryl Sudafed Imodium AD Pepto-Bismol
- Clariton Antacid Midol
- Other _____

Can your child swim? Yes No Are they allowed to swim in a public pool? Yes No

Does your child have a current condition for which treatment or medication is required? If so, please complete a Physician's Request for Administration of Medicine form.

PRINTED NAME OF PARENT//GUARDIAN SIGNATURE DATE