WASHINGTON TOWNSHIP PUBLIC SCHOOLS
SCHOOL TRIP MEDICAL INFORMATION

Dear Parents:

We are happy that your son/daughter is planning to attend Orlando, FL-Universal/Disney on 3/18/25-3/22/25. **Please complete this emergency health form and return by 9/20/24 to** Mrs. Luckiewicz 11-12 Nurse email it to **KLuckiewicz@wtps.org**

GENERAL INFORMATION **Student's Cell#:** _____

Student's Name_____D.O.B._____Age_____
(Last) (First)

Address:_____
(Street address) (Town) (Zip code)

Parent/Guardian Contact Information: Name _____

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____

If your parent(s)/guardian(s) cannot be reached, and it is an **emergency**, we should call:

_____ _____ _____
(Name) (Relationship) (Telephone Number)

MEDICAL INFORMATION

Has the child had any history of heart condition, asthma, epilepsy, allergies, diabetes, bleeding disorder or other health condition?

Yes___ No ___ if yes, identify & explain condition _____

_____

Is the child allergic to anything such as foods, medicine, etc.? Yes ____ No ____ If so, what? _____

What signs of an allergic reaction does your child have? _____

What does the child take for an allergic reaction? _____

Does your child take any medication on a daily basis? Yes____ No_____ If yes, please list_____

Will they be taking the medications listed on the trip? Yes_____ No_____. (Physician stamp/signature on this form agrees that -

I need the nurse on this trip to administer the medication(s) Yes_____ No_____ (-student can self-carry & administer if checked No)

Family Physician _____ Address:_____ Phone # (__)_____

List all medications your child will be bringing on this trip, including over-the-counter medications:

DRUG	DOSE (mg and *interval*)	REASON TAKING DRUG

A COPY OF YOUR CURRENT INSURANCE CARD SHOULD BE CARRIED BY THE STUDENT

This page maybe duplicated to update health issues/medication orders prior to the trip.

IF ANY MEDICAL CHANGES OCCUR TO YOUR STUDENTS, A NEW FORM MUST BE COMPLETED

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I give permission for my child to self-administer the above medication, which will be in their original container(s***) and they will bring only the amount needed for dates of trip.*** *I have reviewed with my child the proper medication administration indications and proper dosages*. I also agree that the Washington Township School District and the trip chaperones shall incur no liability as a result of an injury arising from the self-administration of medication by my child. I give permission to share this medical information on a need-to-know basis.

In case of injury/illness/incident, I hereby authorize: (1) The school nurse and/or attending physician to provide the necessary emergency treatment; (2) The use of my insurance to cover medical treatment; and (3) Parent/Guardian agrees to be financially responsible for expenses incurred by Washington Township High School in the event their child does not have medical insurance coverage.

PARENT/GUARDIAN SIGNATURE _____ **PRINT NAME** _____ **DATE** _____

PHYSICIAN'S SIGNATURE _____ **PRINT NAME** _____ **OFFICE STAMP** _____

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