WASHINGTON, DC
HEALTH INFORMATION FORM

Student information:

Student's last name	Student's first name	Date of birth	LC/Advisor

Street address	Home phone

Parent/Guardian information:

Name	Relationship	Primary day time phone	Primary evening phone

Name	Relationship	Primary day time phone	Primary evening phone

Emergency contact information:

List two nearby neighbors or relatives who would assume responsibility for your child if we cannot reach you:

Name:	Phone:	Relationship:

Name:	Phone:	Relationship:

Medical information:

Please complete the items listed below. If not applicable, please put "N.A" on the line provided.

1. Student's Physician: _____
   Name Phone number
2. List any allergies to foods, medications, insect bites, etc.
   _____
   _____
3. Please list any health problems your child has?
   _____
   _____
4. List any medications your child takes on a daily basis.
   _____
   _____
5. List any medications that are **ESSENTIAL** for your child **to receive on the trip**. Frequently medication times can be adjusted and can be given by a parent before or after the trip.
   _____
   _____

   ****PLEASE NOTE THAT THE PHYSICIANS ORDER AND MEDICATION MUST BE RECEIVED AT LEAST 1 WEEK PRIOR TO THE TRIP****
6. **MEDICAL EMERGENCY:**
   In the event I cannot be reached, I hereby give my permission to the physician selected by the school to hospitalize, secure proper treatment for my child. I understand that every effort will be made to contact the parent/guardian and the physician of the participant.

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____