

Paxon Hollow Middle School Health History/Permission Form 2008-2009 School Year

Child's Name _____ has my/our permission to participate in all Paxon Hollow Middle School Field Trips unless/until revoked in writing by me/us. I/We understand all of the rules and regulations as it pertains to the Paxon Hollow Middle School, and we agree that our child shall abide by them. I also certify that my/our child is in good health, with no present medical or psychiatric conditions that would prevent full participation in the activity. ***If there is any change in my child's physical condition, it is my/our responsibility to so notify the school and complete a new health form.***

In case of emergency, those duly authorized nurses, teachers, and/or chaperones have my/our permission to act on my/our behalf in the best interest of my/our child, including medical treatment, and will hold harmless any staff member and/or trip nurse that administers said treatment.

Personal History:

Grade _____ Male _____ Female _____ Date of Birth _____

Present Address _____

Phone: _____

Parent or Legal Guardian _____
Please Print Last, First Middle

Other people to call in case of emergency: (Please print)

1. _____
Name Home Phone Work Phone
Relationship _____

2. _____
Name Home Phone Work Phone
Relationship _____

Please contact the school nurse to discuss any special medical conditions or medications

Health History: (Please give dates where known)

Operation (within the past year) _____

Emotional Problems (i.e. hyperventilation, hysteria) _____

Serious Medical Problems _____

Rheumatic Fever _____

Allergy _____

Diabetes _____ Epilepsy _____ Contact Lenses _____

Date of Last Tetanus Shot _____

Any Special Health problems in the past _____

Specific Allergy to Drugs _____

Any medication that child is on _____

Is your child under medical treatment at this time? _____

If yes, please state reason _____

Family Physician _____

Phone _____

As per school board policy each participant must have Accident and Medical Insurance to participate in any activity.

By signing below, you are stating that you understand this policy and have coverage Accident and Medical Insurance

Insurance Company _____

Agreement/Identification number _____

Signature _____

Parent/Legal Guardian

Date

Signature _____

Print

All Information will be kept strictly confidential