DETROIT PUBLIC SCHOOLS

CONFIDENTIAL STUDENT HEALTH FORM

NAME OF EVENT: ____

DESTINATION: ____

TRAVEL DATES: ______________________ **TO** ______________________

SCHOOL: ______________________________

GENERAL INFORMATION -

STUDENT'S NAME: ____________________________________ DATE OF BIRTH: ___/___/____

HOME ADDRESS: ___________________City __________State ______ Zip______

PARENTS/GUARDIAN: __________________________ Home Phone (__)_______ Office (___)_______

MEDICAL HISTORY -

Does student have diabetes, epilepsy, allergies or other health problems? __No __Yes
If yes, please specify____

Is student currently taking any medication (include antihistamines, aspirin, tranquilizers, insulin)? __No __Yes If yes, please specify____________________________________

Is student currently under medical treatment? ___No ___Yes
If yes, please explain____

Any other information that the director, chaperones and escort should be aware of?
___No ___Yes If yes, please explain____

PHYSICIAN: ____

Home Phone (____)___________ Office Phone (____)___________

HEALTH INSURANCE COMPANY: ______________ Policy # __________ Group #__________

PARENT OR LEGAL GUARIAN CONSENT:

I (we) hereby give permission for the above-named student to be treated by a physician or licensed nurse at a hospital or on the scene in the event of a medical emergency. I (we) understand that the director, chaperones, escort and/or medical personnel will be acting in the best interest of my (our) child, and I (we) will not hold them responsible for any decisions they make.

NAME (PRINT) ______________________________ ______________________________

SIGNATURE (s) ______________________________ ______________________________

Today's Date: ______________________