FRISCO ISD
School Health Services

STUDENT HEALTH INFORMATION FOR OVERNIGHT FIELD TRIPS

Student Name: _____ Sex M F Date of Birth: _____ GR: _____
Address: _____

Parents/Legal Guardians

Name: _____ Relationship to Student: _____
Home Phone: _____ Cell: _____ Work: _____
Place of employment: _____ Email: _____
Name: _____ Relationship to Student: _____
Home Phone: _____ Cell: _____ Work: _____
Place of employment: _____ Email: _____
Physician's name: _____ Phone Number: _____

Please circle yes or no of any factors or medical conditions of which school officials should be aware:

ADD/ADHD: **Yes/No** Diabetes: **Yes*/No** Medications taken regularly: **Yes*/No**
Serious illness or accident: **Yes/No** Allergies: **Yes*/No** Disability: **Yes/No**
Recent surgeries: **Yes/No** Asthma: **Yes*/No** Hearing/Vision: **Yes/No**
Seizure (Disorder or history of): **Yes*/No** Other: _____
Please explain fully any "yes" answers: _____
_____

**Please see school nurse for additional forms to complete*

I request that Frisco ISD personnel administer the following medications to my child while on the field trip. All medications must be in the original container and must be properly labeled. I do hereby release the Frisco ISD, its agents, servants, employees and medical advisors from any and all liability in connection with the administration of this medication.

Medication: _____ Medication: _____
Time: _____ Time: _____
Dosage and Route: _____ Dosage and Route: _____
Reason medication given: _____ Reason medication given: _____
_____ _____

District approved medications include: Acetaminophen (Tylenol), Ibuprofen (Advil/Motrin), Tums, Benadryl, cough drops, and throat strips. Generic equivalents are acceptable.

Parent/Guardian Signature: _____ Date: _____