

FIELD TRIP MEDICAL FORM

LONDONDERRY SCHOOL DISTRICT  
Londonderry, New Hampshire 03053

SCHOOL HEALTH SERVICES

Please print or type the following information:

STUDENT NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_  
PARENT/GUARDIAN \_\_\_\_\_ PHONE# \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_  
SCHOOL \_\_\_\_\_ PHONE# \_\_\_\_\_  
TEACHER'S NAME \_\_\_\_\_  
HEALTH INSURANCE COMPANY \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_

IN CASE OF EMERGENCY NOTIFY

NAME \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_  
BUSINESS ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_

HEALTH HISTORY

HEART TROUBLE (Explain) \_\_\_\_\_  
BLACKOUTS/CONVULSIONS (Explain) \_\_\_\_\_  
ASTHMA OR BRONCHITIS \_\_\_\_\_  
DIABETES (Detail of treatment & control) \_\_\_\_\_  
\_\_\_\_\_

DATE OF LAST TETANUS IMMUNIZATION \_\_\_\_\_

ALLERGIC REACTIONS

BEE STING \_\_\_\_\_ PENICILLIN \_\_\_\_\_  
DRUGS (List) \_\_\_\_\_  
OTHER \_\_\_\_\_

ARE THERE ANY ILLNESSES FOR WHICH THIS CHILD IS CURRENTLY RECEIVING  
TREATMENT AND/OR MEDICATIONS? YES \_\_\_\_\_ NO \_\_\_\_\_

PLEASE DESCRIBE AND LIST MEDICATIONS \_\_\_\_\_  
\_\_\_\_\_

IN CASE OF MEDICAL EMERGENCY, I HEREBY AUTHORIZE ANY LICENSED PHYSI-  
CIAN, HOSPITAL, CLINIC, OR OTHER MEDICAL FACILITY TO HOSPITALIZE AND SE-  
CURE PROPER TREATMENT FOR TREATMENT FOR MY CHILD AS NAMED ABOVE.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_  
Parent/Guardian

Reviewed by School Nurse \_\_\_\_\_ R.N.  
Date \_\_\_\_\_