NORTH HUNTERDON-VOORHEES REGIONAL HIGH SCHOOL DISTRICT

C5

MEDICAL INFORMATION AND AUTHORIZATION FOR OVERNIGHT FIELD TRIP NAME OF STUDENT:____ Last First HOME ADDRESS:____ **MEDICAL INSURANCE** (Please list Insurance Company and Policy Code or Identification Number) Primary Insurance_____ Secondary Insurance_____ PHONE NUMBERS/REACH NUMBERS FOR PARENTS OR GUARDIANS (Please include home number, work numbers and cell phone numbers) Name of Parent/Guardian_____ Phone numbers _____ Name of Parent/Guardian_____ Phone numbers _____ MEDICAL CONDITIONS/ MEDICATIONS Please list ALL Medical Conditions (use extra pages, if necessary) Please list ALL Medications (use extra pages, if necessary)

ALLERGIES

Please list all Allergies (use extra pages, if necessary)				
QUESTIONS (Please circle the correct answer)				
Does you child carry an Epipen?	O Yes	No		
Does your child carry an inhaler?	O Yes	No		
Does your student have any additional s If yes, please indicate:	pecial health	needs? Yes	ONo ⊙	
RELEASE	OF INFOR	MATION		
Parent/Guardian I hereby authorize the North Hunterdon information provided above and in my school to trip chaperones, including so as any medical personnel deemed neces	child's stud hool personn	ent health rec lel and non-sc	cords maintained by the	
The effective dates of this authorization are to (date of		to (date of return)		
Signature of Parent/Guardian	Dat	e:	, 20	
	Dat	te:	, 20	
Signature of Parent/Guardian Sworn to and subscribed before me this day of, 20				
Notary Public				

Student over the age of 18 (student must sign if 18 years in age or older)

G:	Date:	, 20
Signature of Student		
Sworn to and subscribed		
before me this		
day of, 20		
Notary Public		
EMERGENCY ME	EDICAL AUTHORIZA	ATION
	agents or representations	a to comment .
School District (the "District") and its a my child's behalf, to any medical/ho outside the U.S.) to be rendered upon the responsible for all necessary charges rendered pursuant to this authorization representatives and agents from all liab any court in relation to this authorization. The effective dates of this authorization	agents or representatives of spital care or treatmer the advice of any license incurred by any hose. I release the District polity and any claim what or any treatment provides	s, to consent, on mine and all (including at locations of physician. I agree to be spitalization or treatment and all of its employees, atsoever that may arise inded.
outside the U.S.) to be rendered upon the responsible for all necessary charges rendered pursuant to this authorization, representatives and agents from all liab any court in relation to this authorization.	agents or representatives of spital care or treatmer the advice of any license incurred by any hose. I release the District polity and any claim what or any treatment provides	nt (including at locations of physician. I agree to be spitalization or treatment and all of its employees, atsoever that may arise in ded.
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outside the U.S.) to be rendered upon the responsible for all necessary charges rendered pursuant to this authorization. The representatives and agents from all liab any court in relation to this authorization. The effective dates of this authorization. Signature of Parent/Guardian.	agents or representatives of spital care or treatmer the advice of any license incurred by any hose. I release the District oility and any claim what or any treatment provider are (date of departure) Date:	s, to consent, on mine and at (including at location of physician. I agree to be spitalization or treatment and all of its employees atsoever that may arise inded.

Student over the age of 18 (student must sign if 18 years in age or older)

I am eighteen (18) years of age or older, h Authorization and confirm that the information	nave read the contained the	above Emergency Medical erein is true and accurate.
	Date:	, 20
Signature of Student		
Sworn to and subscribed before me this day of, 20		
Notary Public		

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