FRISCO INDEPENDENT SCHOOL DISTRICT
School Health Services

STUDENT HEALTH INFORMATION FOR FIELD TRIPS

Student Name _____ Sex M F Date of Birth _____Grade_____

Address _____

Parents/Legal Guardians

Name _____Relationship to Student _____Home Phone _____

Place of employment _____ email _____ Work Phone _____ Cell _____

Name _____Relationship to Student _____Home Phone _____

Place of employment _____ email _____ Work Phone _____ Cell _____

Physician's name _____ Phone Number _____

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

_____ADD/ADHD _____ Diabetes * _____Medications taken regularly* _____Serious illness or accident

_____Allergies* _____ Disability _____Recent surgeries

_____Asthma* _____ Hearing/Vision _____Seizure (Disorder or history of)*_____Other

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

Please explain fully any "yes" answers _____

_____

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: _____

_____ _____

Parent/Guardian Signature _____ Date ___ _____

Revised May 2013