Pembroke High School

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Medical form for students on Overnight & Out of State Trips

Please return this form to your trip coordinator at least ONE MONTH prior to trip departures.

Program Information:
Field Trip Coordinator: (FTC) ____
Title or Name of Field Trip, Activity, or Program: ____
Dates: ___________________________ Location(s) of event: _________________________________
Location of nearest medical facility for emergency care: ____________________________________

Student Information:
Student's Name: ____ DOB: _________________________
Home Address: ____
Parent/Guardian Phone: _____________________ Cell #1 __________________ Cell #2 _______________
Emergency Contact: _________________________ Phone: __________________ Cell: ________________
Health Insurance Provider: ____________________ Health Insurance Policy Number: __________________
Primary Subscriber of Medical/Health Policy: ____
Student's Primary Health Care Provider: __________________________________ Phone: ______________

Allergies: Yes ______ No ______ Please list: ____
Epinephrine: Yes ______ No ______ Asthma: Yes ____ No ___ Inhaler: Yes ____ No _____
Diabetes: Yes ______ No ______ Seizures: Yes ____ No ___
Medical Concerns: ____
____

Medications needed on trip: Yes ______ No ______

*Please send only medications that are regularly taken by the student and are medically necessary.

Please list: ____
____

*Physician's order for medications must be brought to the health room at least three days before the trip.
Only send the amount of medication needed for the trip with the student.
All medications must be in a pharmacy labeled container with name, medication, dosage and frequency of administration.
If school policy permits, the school nurse and the parent will decide if the student is capable of self-administration. The nurse has the final decision concerning self-administration.

Parent/Guardian signature: ____ Date: _______________

Physician signature: ____ Date: ____________