NORTH READING PUBLIC SCHOOLS EMERGENCY INFORMATION

Complete the following information and return to school immediately.

The information and permissions given on this form are limited to use in connection with the North Reading High School trip to Walt Disney World, for the time period of April 26, 2022 – May 1, 2022. All information on this form is to be current for that time period.

Name of Student: Date of Birth: Sex: M F Grade:

Address: Home Phone:

Mother/Guardian/Other: Email Address: Cell Phone:

Home Address: Home Phone:

Work Address: Work Phone:

Father/Guardian/Other: Email Address: Cell Phone:

Home Address: Home Phone:

Work Address: Work Phone:

IN THE SECTION ABOVE, PLEASE CIRCLE THE ONE PHONE NUMBER THAT SHOULD BE USED FIRST AS A CONTACT IN CASE OF EMERGENCY. (If there is no response at that number, other numbers will be tried until contact is made.)

Does your child have health insurance: Yes ☐ No ☐

Health Insurance Company: Policy Number:

IN CASE OF AN EMERGENCY WHILE ON THIS TRIP, IF YOU OR PERSON(S) DESIGNATED CANNOT BE REACHED, YOUR CHILD MAY BE TAKEN TO A HOSPITAL OR EMERGENCY TREATMENT FACILITY TO RECEIVE CARE. PLEASE PROVIDE THE FOLLOWING CONTACT INFORMATION IN CASE WE NEED TO CONTACT MEDICAL PROFESSIONALS IN AN EMERGENCY.

Physician: Phone:

Dentist: Phone:

Please list all medical conditions that your child has (if not in violation of confidentiality):

Please list all medications that your child takes and the reasons for the medications (if not in violation of confidentiality):

Please check all that apply to your child:

☐ Allergies (food, insects, medication, environment) please specify: _____

Emergency Treatment for Allergies: _____

☐ Asthma ☐ Diabetes ☐ Heart Condition ☐ Migraines ☐ Seizures ☐ Physical Limitations

☐ Hearing problems (please specify): _____ ☐ Wears Hearing Aids

☐ Vision problems (please specify): _____ ☐ Wears Eyeglasses ☐ Wears Contact Lenses

In case of minor problems such as allergy symptoms or pain without fever, I give permission for the adult chaperones to give my child common over-the counter medications: Yes ☐ No ☐

Please specify any specific over-the counter medications that your child may **not** receive:

I give permission to the adult chaperones to share information relevant to my child's health, including possible medication side effects, with appropriate emergency care providers when necessary for my child's health and safety. Yes ☐ No ☐

Signature of Parent/Guardian: **Date:**