

Los Angeles Unified School District Field Trip Personal Health History Form

This form is to be completed by the parent/guardian for students attending a field trip.

A. STUDENT INFORMATION			
Student Name:	Date of Birth:	Gender:	Grade:
Teacher:	Field Trip Destination:		
B. PARENT/GUARDIAN/CAREGIVER INFORMATION			
Parent/Guardian Name:	Home Phone Number:	Cell Phone Number:	
Work Phone Number:	Email Address:		
C. EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT/GUARDIAN/CAREGIVER)			
Emergency Contact Name:	Cell Phone Number:	Other Phone Number:	
Relationship:	Email Address:		
D. STUDENT EDUCATION INFORMATION			
Does the student have a current Individualized Education Program (IEP) at their school?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the student have a current Section 504 Plan at their school?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. ALLERGIES (CHECK ALL THAT APPLY)			
<input type="checkbox"/> Food Allergy (list/describe reaction): _____ _____			
<input type="checkbox"/> Medication (list and describe reaction): _____ _____			
<input type="checkbox"/> Insect Bites/Stings (list and describe reaction): _____ _____			
<input type="checkbox"/> Seasonal (explain): _____			
<input type="checkbox"/> Other (explain): _____			
<input type="checkbox"/> Does your child take medication for allergies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> If yes, list the name(s) of the medication taken/prescribed: _____ _____			
<input type="checkbox"/> None			
F. STUDENT HEALTH INFORMATION			
Does the student have a current health condition? Check all that apply.			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Musculoskeletal disorder		
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Seizures		
<input type="checkbox"/> Constipation	<input type="checkbox"/> Wears glasses/contact lenses		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Emotional/Psychological Condition	<input type="checkbox"/> Specialized physical health care procedure. If checked, type of procedure: _____		
<input type="checkbox"/> Heart defect/disease	_____		
<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> None		

Los Angeles Unified School District Field Trip Personal Health History Form

Explain health condition(s) checked above: _____

Does the student have any physical limitations? If yes, please explain: _____

Does the student have any dietary restrictions? If yes, please explain: _____

G. MEDICATION

Does the student need medication during the field trip? If "Yes", see numbers 1, 2 and 3 below.

Yes^{1, 2, 3} No

1. To administer routine over-the-counter medications to be taken during an overnight field trip, parents/guardians must obtain a completed ***Request and Prior Authorization for Over-the-Counter Medication to be Taken During Overnight Field Trips*** form, which includes a parent/guardian signature consent and a written order from the health care provider.
2. To administer medication (prescription and over-the-counter medications not listed on the above referenced form in #1) on the field trip, parents/guardians must obtain a completed ***Request for Medication to be Taken During School Hours*** form, which includes parent/guardian signature consent and a written order from the health care provider.
3. The completed ***Request for Medication to be Taken During School Hours*** and/or ***Request and Prior Authorization for Over-the-Counter Medication to be Taken During Overnight Field Trips*** form(s) must be returned to the school **at least 7 days prior to departure** with parent/guardian and health care provider signatures

In the event of a medical emergency, 911/Emergency Medical Services will be called, and the student will be transferred to the nearest medical facility.

H. ADDITIONAL HEALTH INFORMATION

Please provide any additional health information about the student.

G. PARENT/GUARDIAN/CAREGIVER CONSENT

I verify that the information contained in this document is true and correct to the best of my knowledge.

X _____
Signature

Date

COMPLETED FORM TO BE GIVEN TO THE SCHOOL NURSE