



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 and may be valid for one school year. For students with identified health conditions, this form may need to be updated more frequently. It is the parent/guardian's responsibility to inform the school nurse of any changes in the student's health condition for future field trips during the current school year.

A. Student Information			
Student Name:	Date of Birth:	Gender:	Grade:
Teacher Name:	School Name:		
B. Parent/Guardian Information			
Parent/Guardian Name:	Home Phone Number:	Cell Phone Number:	
Work Phone Number:	Email Address:		
C. Emergency Contact Information (Other Than Parent/Guardian)			
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. Does the student have allergies? If yes, check all that apply:			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Food Allergy (list and describe reaction): _____ _____			
<input type="checkbox"/> Medication Allergy (list and describe reaction): _____ _____			
<input type="checkbox"/> Insect Bites/Stings Allergy (list and describe reaction): _____ _____			
<input type="checkbox"/> Seasonal Allergy (Explain): _____ _____			
<input type="checkbox"/> Other (Explain): _____ _____			
<input checked="" type="checkbox"/> Does your child take medication for allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the name(s) of the medication taken/prescribed: _____ _____			



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F. Does the student have a current health condition? If yes, please check all that apply: Yes No

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Musculoskeletal Disorder |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Seizure Disorder |
| <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 Healthcare Procedure. If selected, document the type of procedure:
_____ |
| <input type="checkbox"/> Heart Defect/Disease | _____ |

Explain health condition(s) selected above: _____

❖ Does the student have any physical limitations? Yes No:
If yes, please explain: _____

❖ Does the student have any dietary restrictions? Yes No:
If yes, please explain: _____

G. Medication

Does the student need medication during the field trip? If yes, see^{#1, 2, 3} below. Yes^{#1, 2, 3} No
Please consult with the school nurse.

- 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 licensed healthcare provider.
- To administer medication (prescription and over-the-counter medications not listed on the above form) 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 licensed healthcare provider.
- 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 licensed healthcare 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. _____

I. Parent/Guardian Consent

I verify that the information contained in this document is true and correct to the best of my knowledge and will notify the school nurse of any changes in the student's health condition.

Parent/Guardian Signature

Date