BOCES Western Suffolk

RESIDENTIAL HEALTH INFORMATION FORM

Dates of Trip_____

TO BE COMPLETED BY STUDENT'S PARENT OR GUARDIAN

NAME OF STUDENT: _____ SCHOOL DISTRICT: _____

ADDRESS: _____ AGE: _____ DOB: _____/_____/_____

_____ GENDER: ☐ Male ☐ Female

PHONE #: (_____) _____

NAME OF PARENT/GUARDIAN: _____

ADDRESS: _____ PHONE #: (_____) _____

_____ CELL PHONE #: (____) _____

BUSINESS ADDRESS: _____ PHONE #: (_____) _____

NAMES AND PHONE NUMBERS OF TWO ADULTS WE CAN CONTACT IN THE EVENT YOU CANNOT BE REACHED:

NAME: _____

RELATIONSHIP: _____ PHONE #: (_____) _____ CELL PHONE #: (___) _____

NAME: _____

RELATIONSHIP: _____ PHONE #: (_____) _____ CELL PHONE #: (___) _____

NAME OF FAMILY DOCTOR: _____ PHONE #: (_____) _____

HEALTH INSURANCE CARRIER: _____ POLICY #: _____

DO YOU KNOW OF ANY HEALTH FACTOR THAT MAKES IT ADVISABLE FOR THE STUDENT TO FOLLOW A LIMITED PROGRAM OF PHYSICAL ACTIVITY? _____ IF SO, PLEASE DESCRIBE AND STATE LIMITATIONS.

_____

_____

My child has permission to carry and use sunscreen and camp staff can assist with the application of sunscreen if my child is unable to do so, provided my child requests the assistance.

The student herein described has my permission to engage in all prescribed activities except as noted by me and/or the student's physician. In the event I cannot be reached in an emergency, I hereby give my permission to the physician, selected by the teacher in charge, to provide first aid treatment as needed.

SIGNATURE _____ **DATE** _____

Parent or Legal Guardian

RESIDENTIAL HEALTH INFORMATION FORM

TO BE COMPLETED BY PHYSICIAN OR NURSE

Name of Student: _____ School District _____

Address _____ Age ____ DOB ____/____/____ Gender: M/F

_____ Phone # (____) _____

Name of Parent or Guardian: _____ Student SS# _____-_____-_____

1. Date of most recent immunization:
   tetanus ____/____/_____ diphtheria ____/____/_____ mumps ____/____/_____ hepatitis b ____/____/_____
   measles ____/____/_____ rubella ____/____/_____ poliomyelitis ____/____/_____
   haemophilus influenza b ____/____/_____ varicella (chicken pox) ____/____/_____
2. List any health conditions, such as heart disease, diabetes, epilepsy, asthma or any chronic condition, etc.
   _____
3. Does the student carry an inhaler? _____
4. Is there any condition the student has that requires medication? _____ If so, what is the condition and the treatment for it? _____
   _____
   If medication needs to be administered, a doctor's note AND parent/guardian's note must be attached to this health form indicating the medication(s) and the instructions regarding dose and frequency.
   PRESCRIPTION MEDICATION MUST BE SENT IN ORIGINAL PHARMACY CONTAINERS.
5. Allergies: If "yes", please indicate type and symptoms.

	Yes/No	
Foods?	_____	_____
Insect stings?	_____	_____
Medications?	_____	_____
Other?	_____	_____

   What treatment does the student receive for the allergic reaction(s)? _____
   _____
6. Has student been exposed to any communicable diseases in the past 21 days? _____
   If so, please indicate disease(s). _____
7. Do you know of any health factor that makes it advisable for student to follow a limited program of physical activity?
   _____ If so, please describe and state limitations. _____
   _____
8. Does the student wear glasses? _____ Contact lenses? _____
9. Dietary restrictions, if any: _____

DR
RN
LPN

SIGNATURE _____ DATE _____
Physician or Nurse

PARENT AUTHORIZATION FORM

1. RECREATIONAL SWIMMING

Name of Student_____Age_____

Address_____ Phone(__)_____

Name of Parent/Guardian_____

Address_____ Phone(__)_____

Business Address_____ Phone(__)_____

School District_____ School_____

Name of Family Doctor_____ Phone(__)_____

The above-named student has my permission to participate in recreational swimming at the following beaches, where village, town, county or state lifeguards will monitor swimming areas:

Cooper's Beach, Southampton
Hither Hills State Park, Montauk
Breakwater Beach District Park, Mattituck
Meschutt Beach County Park, Hampton Bays

2. BAY INVESTIGATION ABOARD THE S.U.N.Y. STONY BROOK MARINE SCIENCE CENTER RESEARCH VESSEL

The above-named student has my permission to participate on the SUNY Stony Brook excursion on Shinnecock Bay scheduled for July 14, 2014, and to engage in all prescribed activities. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the teacher in charge to administer appropriate first aid and/or medical treatment to my child.

Regarding boat activities: Prior to arrival on Long Island, if prone to motion sickness, participants may wish to consult a doctor or pharmacist to purchase an over-the-counter medication for use while on Shinnecock Bay (relatively flat water).

3. PHOTO RELEASE ☐

Please check the box if you DO NOT give permission for photos of your child participating in the program to be used by WSBOCES.

SIGNATURE_____ **DATE**_____
Parent or Legal Guardian