

**DEVON PREPARATORY SCHOOL
FIELD STUDIES PROGRAM
Health Information Form**

Student's Name _____ Grade _____ D.O.B. _____

Social Security # _____ Student Cell Phone _____

Address _____ City _____ Zip _____

Telephone _____ Parent's Name _____

Work Phone: Father _____ Mother _____

Cell Phone: Father _____ Mother _____

Family Physician _____ Phone Number _____

Health History of Student

Date of last Tetanus shot _____

Please check if student has had a history of:

Diabetes _____	Scarlet Fever _____	Heart Condition _____
Rheumatic Fever _____	Asthma _____	Seizures _____
Ear Condition _____	Hemophilia _____	Other _____

(Please specify condition below)

Any known allergies? Please specify _____

I give my permission for my son to be given Tylenol for pain/fever if necessary. Yes _____ No _____

Students may not carry any medications. Prescription or OTC medication necessary on the trip MUST be in original pharmacy/manufacturers container, with student's name, date of prescription, medication name, dosage and frequency on the label. Please list any medication and dosage below, and have item(s) to Mrs. Gavin no later than 5 school days before departure date.

(Please refer to *Health Room Policy* card regarding correct procedure)

Activities to be restricted: If yes, please specify and attach physician's statement.

Parent's Comment: _____

Medical Insurance Company _____

Policy Number _____

Prescription Plan _____

Policy Number _____

Parent's Signature

Date