ADULT EMERGENCY MEDICAL PERMIT

PLEASE FILL OUT AND SIGN BOTH SIDES OF THIS FORM!

PLEASE PRINT OR TYPE

Name	Person to Contact in Case of Emergency
Address	Emergency Phone (Area Code) Cell Phone (Area Code)
City, State, Zip	Work Phone (Area Code)
Home Phone (Area Code)	Additional Person to Contact in Case of Emergency
Date of Birth	Emergency Phone (Area Code) Cell Phone (Area Code)
Family Physician	Physician Phone (Area Code)
Insurance Company & Policy Holder	Policy Number

HEALTH HISTORY

Check the appropriate categories below if you are currently having or have had any of these medical problems. Please give approximate dates.

	Yes	No		Yes	No		Yes	No
Ear Infections			Chicken Pox			Hay fever		
Rheumatic fever			Measles			Ivy poisoning		
Convulsions			German Measles			Insect stings		
Diabetes			Mumps			Penicillin		
Behavior			Asthma			Food types		
Heart Problems			Bee Sting allergy			Other (specify)		

Please explain any problem areas identified above:

Please check **YES** or **NO** and sign at the bottom to give permission for you to receive the following over-the-counter medication if needed:

	YES	NO		YES	NO
Ibuprofen 200mg x 2 tablets (i.e. Motrin)			Acetaminophen 500 mg x 2 tablets (i.e. Tylenol)		
Dramamine 50 mg x 2 tabs			Pepto-Bismol		
Robitussin cough syrup			Benadryl 25 to 50 mg tabs		

Signature _____ Date _____

**********PLEASE FILL OUT THE BACK OF THISFORM**********

IMPORTANT: *Please fill out as completely as possible.*

MEDICATIONS:	DOSAGE:
_____	_____ _____
_____	_____ _____
_____	_____ _____
_____	_____

Allergies/allergic reactions/allergic reactions to medications: _____

Major surgery in past year: _____

Acute or chronic medical conditions: _____

Physical conditions that limit activities:

_____

Special dietary needs: _____

I understand that the Fraser Public Schools shall not be, nor later become, liable or responsible in any way in conjunction with services, for any death, injury, damage, delay or irregularity which may occur while participating in this activity.

Also, in case of emergency, I hereby give my consent for a qualified physician to perform any medical or surgical procedures she/he deems necessary to my welfare while participating in the Band trip. Further, this authorization permits said physician to hospitalize, secure appropriate consultation, order injections, anesthesia (local, general, or both) or surgery if such emergency conditions warrant. The undersigned does hereby assume and agree to pay any indebtedness or physician's or surgeon's fees and hospital charges for such service.

Signature _____ Date _____