

PATS Program
Health History Report/Medical Authorization Form
(To Be Completed By Parent or Guardian)

PLEASE TYPE OR PRINT

Student's Name: _____ Date of Birth _____

Address: _____

Parent/Guardian(s) _____

Home Phone: _____ Work Phone: _____

Does your student have any allergies? _____

Does your student receive allergy injections? _____

Does your student have Epilepsy? _____ Diabetes? _____ Asthma? _____ Other _____

Explain: _____

List any current medications your student regularly takes _____

Will your student have any medication with him/her during the trip? Yes _____ No _____
If yes, what medication? _____

HEALTH INSURANCE (THIS MUST BE COMPLETED FOR ALL PARTICIPANTS):

Does your student have Health Insurance Coverage? Yes _____ No _____

Physician _____ Phone Number _____

Company Name _____ City of Company _____

ID Number _____ Group Number _____

Subscriber's Name _____ Relationship to Subscriber _____

PARENT/GUARDIAN AUTHORIZATION:

This information is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed program activities, except as noted by me. I hereby give my permission for routine emergency medical treatment at the nearest hospital by the PATS Program Staff.

Signature _____ Date _____

Relationship to Student _____ Telephone # _____

EMERGENCY NOTIFICATION: Specify person to be notified if above parents are unavailable. We will attempt to contact parents first.

Name _____ Relationship _____

Address _____

Telephone Numbers: Home _____ Work _____