Dear Parents:

We are happy that your son/daughter is planning to attend Orlando, FL-Universal/Disney on **3/17/26-3/21/26**.

**Please complete this emergency health form and return by 9/19/25 to** Mrs. Luckiewicz 11/12 Nurse or email **kluckiewicz@wtps.org**

**GENERAL INFORMATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student’s Cell#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Student’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street address) (Town) (Zip code)

**Parent/Guardian Contact Information:** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone ( ) Work Phone ( ) Cell Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your parent(s)/guardian(s) cannot be reached, and it is an **emergency**, we should call:

­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Relationship) (Telephone Number)

**MEDICAL INFORMATION**

Has the child had any history of heart condition, asthma, epilepsy, allergies, diabetes*,* bleeding disorder or other health condition?

Yes\_\_\_ No \_\_\_ if yes, identify & explain condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child allergic to anything such as foods, medicine, etc.? Yes No If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What signs of an allergic reaction does your child have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does the child take for an allergic reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child take any medication on a daily basis? Yes\_\_\_\_ No\_\_\_\_\_ If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will they be taking the medications listed on the trip? Yes\_\_\_\_\_ No\_\_\_\_\_. (Physician stamp/signature on this form agrees that -

**I need the nurse on this trip to administer the medication(s)** **Yes\_\_\_\_\_ No\_\_\_\_\_** (-student can self-carry & administer if checked No)

Family Physician Address: Phone # ( )­­­­­­\_\_\_\_\_\_\_\_\_

**List all medications your child will be bringing on this trip, including over-the-counter medications:**

|  |  |  |
| --- | --- | --- |
| **DRUG** | **DOSE (mg and *interval*)** | **REASON TAKING DRUG** |
|  |  |  |
|  |  |  |
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|  |  |  |

I give permission for my child to self-administer the above medication, which will be in their original container(s***) and they will bring only the amount needed for dates of trip.*** *I have reviewed with my child the proper medication administration indications and proper dosages.* I also agree that the Washington Township School District and the trip chaperones shall incur no liability as a result of an injury arising from the self-administration of medication by my child. I give permission to share this medical information on a need-to-know basis.

In case of injury/illness/incident, I hereby authorize: (1) The school nurse and/or attending physician to provide the necessary emergency treatment; (2) The use of my insurance to cover medical treatment; and (3) Parent/Guardian agrees to be financially responsible for expenses incurred by Washington Township High School in the event their child does not have medical insurance coverage.

**PARENT/GUARDIAN SIGNATURE PRINT NAME DATE**

**PHYSICIAN’S SIGNATURE PRINT NAME OFFICE STAMP \_\_\_\_\_\_**