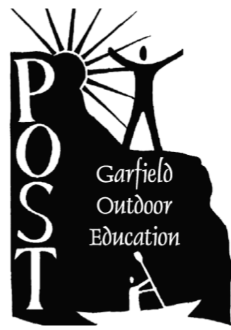
IMPORTANT MEDICAL INFORMATION



Student Name:________________________________ Date of Birth:___________________

Primary Care Physician's Name and Phone Number:

Health Insurance Provider's Name, Policy # and Contact Info:

Insurance Provider's Claim Instructions/Procedures:

Please list any health issues POST should be aware of (physical or mental):

Allergies/Food Restrictions:

Please list any medications and/or prescriptions POST should be aware of:

List Requirements/Directions for administration of this medication:

Specify symptoms or reaction when medication is taken:

IMPORTANT MEDICAL INFORMATION (cont.)

Are there any circumstances in which your student should limit his or her physical activity, (e.g. asthma, recent injury etc.) If yes, please specify:

Additional medical information POST needs to know in regards to your student's health (physical or mental):

I authorize the release of the information above to POST trip leaders, Chaperones, and staff in order to maintain the safest environment for your student.

Student Signature (if over 18 years old):________________________________Date_____________

Parent Signature(if under 18 years old):________________________________Date_____________