

PLEASE PRINT CLEARLY

THE BROMFIELD SCHOOL

TRIP MEDICAL INFORMATION AND EMERGENCY CONTACTS

CHILD'S NAME: _____ DATE OF BIRTH: _____

MAY TYLENOL BE GIVEN: *yes* *no* MAY IBUPROFEN BE GIVEN: *yes* *no*

ALLERGIES TO MEDICATIONS OR FOOD: _____

MEDICATIONS PRESENTLY TAKING: _____

CHILD'S DOCTOR AND PHONE NUMBER: _____

INSURANCE POLICY NAME & NUMBER: _____

PARENT'S FULL NAMES: FATHER _____

MOTHER _____

FATHER'S HOME PHONE: _____ CELL PHONE: _____

FATHER'S WORK PHONE: _____

FATHER'S WORK HOURS: _____

MOTHER'S HOME PHONE: _____ CELL PHONE: _____

MOTHER'S WORK PHONE: _____

MOTHER'S WORK HOURS: _____

If any of the above information is not applicable, please write N/A in the space.

Name and phone number of a close relative or friend that may be contacted in the event that a parent cannot be reached and an emergency arises:

Name: _____

Relationship: _____

Phone Number: home _____ work _____

PARENT SIGNATURE: _____ DATE: _____

PLEASE PRINT CLEARLY

PARENTAL CONSENT

I, _____, authorize _____
_____ to act on my behalf concerning any medication
and/or medical treatment that may become necessary for my son/daughter _____
during the time commencing on _____ and terminating on and including
_____.

I understand that the above named as authorized and others will use all reasonable efforts to contact me in the event of an emergency. Failure to do so, however, should not prevent rendering of necessary emergency treatment.

DATE: _____ PARENT SIGNATURE: _____

DATE: _____ PARENT SIGNATURE: _____

I agree to reimburse the Harvard Public Schools or _____
_____ for any medical expenses incurred if my insurance is not accepted as
payment. I understand all reasonable efforts will be made to contact me, and that appropriate receipts will
be furnished so that I may make my own claim to my insurance company.

DATE: _____ PARENT SIGNATURE: _____