

Name _____ Sports _____

EMERGENCY / MEDICAL AND FIELD TRIP INFORMATION

Age _____ Grade (2010-2011) _____ Birth Date _____ Gender _____
Address _____ City _____ State _____ Zip _____
Dad's Name: _____ Dad (H): _____ Dad (C) _____ Dad (W) _____
Mom's Name: _____ Mom (H): _____ Mom (C) _____ Mom (W) _____
If parents cannot be reached: Name: _____ Relation: _____ Phone: _____

1. My Child has had the following: (Please check)
- | | | | |
|-------------------|-----------------------|---------------------------|------------------------------|
| _____ Allergies | _____ Diabetes | _____ High Blood Pressure | _____ Serious Injury |
| _____ Asthma | _____ Dizziness | _____ Kidney Disease | _____ Surgery |
| _____ Epilepsy | _____ Measles | _____ Tires easily | _____ Bone or Joint Problems |
| _____ Chicken Pox | _____ Fainting Spells | _____ Mumps | _____ Bleeds freely |
| _____ Convulsions | _____ Heart Trouble | _____ Rheumatic Fever | |

If your child had any of the above conditions, did he/she receive medical care? _____ Yes _____ No

2. Has your child had a complete physical within the past year? _____ Yes _____ No

3. Is your child on medication at this time: _____ Yes _____ No

If so what? _____ For What Condition? _____

4. Is your child under medical care at this time: _____ Yes _____ No

If so what? _____ For What Condition? _____

5. Is your child eligible for Medicaid? _____ Yes _____ No

6. Name of Insurance Company _____ Policy/Group# _____

Policy Holder's Name: _____ Insurance Phone Number _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below AND to follow his instructions. If it is impossible to contact this physician, the school may take whatever arrangements seem necessary. If unable to name a physician or pay for medical services, then medical, hospital or welfare services may be authorized. **I understand that LTISD does not carry insurance, catastrophic or other, on my child and that I am responsible for payment of any injuries incurred. I also understand that there is a secondary insurance plan that is available for purchase.**

7. Known Drug Allergies: _____

8. Local Physician's Name: _____

9. Address: _____ Office Phone _____

10. Hospital preference in case of emergency: _____

Please include any further comments concerning your child's health that you would like the school to know.

I have completed all of the above information and do hereby confirm it is true and accurate.

Signature of Parent / Guardian _____ Date _____

Field Trip Information: I hereby grant permission for my child named above to make any and all field trips in or out of the limits of the Lake Travis Independent School District made by his grade of section under the auspices and sponsorship of Lake Travis Independent School District. Some of these trips will be walking ones to points of interest near the school, while others will be motor bus operated and insured as required by the laws of the State of Texas or public school transportation.

I further understand children will be informed in advance of any proposed trip so they may inform their parents.

Signature of Parent / Guardian _____ Date _____