

HEALTH & EMERGENCY CARE FORM

MUST be completed yearly

Date _____

Student _____ Grade _____ Date of Birth _____

- Students must have the following immunizations on file at LTS prior to the first day of school
 - ✓ 5 DTaP/DTP and 1 Tdap booster (last one within 10 years)
 - ✓ 4 POLIO VACCINES
 - ✓ 2 MMR
 - ✓ 3 HEPATITIS B VACCINES (Gr. 7-11)
 - ✓ 2 VARICELLA (laboratory proof of immunity is acceptable in lieu of vaccination history or a signed department-supplied form is completed by a parent/guardian indicating the student has a history of disease)
- Updated immunization records are required if a returning student has had any of the above immunizations within the past year.
- All new (domestic and international) students MUST attach a current copy of their immunization record listing the dates the above immunizations were administered.

Yes No Has your child had a routine health exam in the last year? If yes, please send a copy to LTS.

Yes No Has your child had any illness or injury within the last year? If yes, is she or he still under treatment?

Yes No Does your child have any known asthmatic conditions or allergies to medications, foods, pollens, bee stings, etc.?

Yes No Does your child take daily medication? If yes, what? _____

NOTE: Prescription medications taken during the school day should be kept in the Student Activities Office.

If your child has any disability, limitations, or health problems, please comment and state how the school can be helpful.



Please enter all information, **sign in three places** and return to the Student Activities Office.

PERMISSION TO PARTICIPATE IN STUDENT ATHLETICS AND ACTIVITIES

I hereby give permission for _____ to participate in the LTS Student Athletics and Activities programs. I realize that such activities involve the potential for injury, both minor and major, which is inherent in all student life programs. My signature indicates that during the school year my child is and will be covered by a legitimate health care plan; I assume full responsibility for this coverage. I understand that students will travel in LTS authorized vehicles, under the direction and authority of authorized coaches/advisors.

Medical Insurance Company _____

Policy Number _____

No insurance coverage

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____



Signature of Parent/Guardian _____

EMERGENCY TREATMENT AUTHORIZATION

Should an emergency arise and neither I nor my family physician (see above) can be reached, I give my permission for the adult in charge to call any physician or to institute emergency care.

Primary contact other than parents _____ Relation _____

Home Phone _____ Work _____ Cell _____

Secondary contact _____ Relation _____

Home Phone _____ Work _____ Cell _____



Signature of Parent/Guardian _____

OTC MEDICATION AUTHORIZATION

Any adult in charge at Long Trail may give my child the following medications: (please circle)

Tylenol Advil Cough Drops Antacid Antihistamine



Signature of Parent/Guardian _____