BETHLEHEM AREA SCHOOL DISTRICT
Bethlehem, Pennsylvania

MEDICAL INFORMATION FORM
to be completed by ALL students

PRINT clearly:

Student name _____
(Last) (First) (Middle Initial)

Address _____

School/Building _____ Grade _____ Date of Birth _____ Age _____

Person to be notified in an emergency:

Name _____

Relationship _____

Contact # _____ Alternate # _____

Primary Physician Information:

Name _____ Phone _____

Address/City/State _____

Insurance Information:

Company Name _____

Insured ID#_____ Group# _____

Primary Subscriber _____ Prescription Plan _____

List allergies to food, medication, animals, etc. If NONE, please state:

_____

List any special medical problems. If NONE, please state:

_____

_____

I/We understand that Bethlehem Area School District staff, other than a nurse or physician employed by the District, cannot legally administer any medication to this student. I/We authorize this student to attend this Bethlehem Area School District approved trip. I/We understand that all valid releases, authorizations, and insurance information provided previously to the District apply to this trip. I/We authorize any necessary medical treatment to this student while participating in the activities associated with this trip. I/We guarantee reimbursement of all charges incurred if medical treatment (physician, hospital, x-ray, labs, drugs, ambulance, etc.) is necessary.

_____ _____
Parent/Legal Guardian Date Parent/Legal Guardian Date