FORM # 34

Medical Form
Passaic County Technical Institute

Name: _____ Age:_____
(Last) (First) (M.I.)

Address: _____ D.O.B. _____
_____ S.S.# _____- _____ - _____
Parent/Guardian Name: _____phone: _____
work: _____
cell: _____
Other Parent/Guardian: _____phone: _____
work: _____
cell: _____
Emergency Contact: _____phone: _____
work: _____
cell: _____
Family Physician: _____phone: _____

Health conditions to be aware of: _____
_____

Activities student should be restricted from: _____
_____

May this student go swimming if facilities are available? _____ yes _____ no

List any allergies, including to any medications, which this student has: _____
_____

List any medications student will be taking on trip: (This list is limited to medications specifically documented in the Health Office and allowed to be self-administered by the student for asthma or other potentially life-threatening illnesses.) _____

**** ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINERS AND PROPERLY LABELED WITH PHYSICIANS INSTRUCTIONS!! ****

Does this student have health insurance coverage? _____ yes _____ no

Insurance Company Name: _____ Policy # _____

In the unlikely event that I cannot be contacted, I give permission for my child to receive emergency medical treatment in case of illness or injury. I understand that I am responsible for any medical expenses not covered by the student insurance policy.

Parent/Guardian signature: _____ Date: _____