

**DES MOINES INDEPENDENT COMMUNITY SCHOOL DISTRICT**  
**Student Out of District Travel Health Information**

**Authorization for Health Care**

Student Name \_\_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_\_

This form provides information for use in case medical care is necessary or advisable during travel out of the district. Information will be kept in strict confidence and will be used only if necessary by authorized adults.

If your student has a special medical problem which occurs after this form is completed and at the time of the trip, please notify the school nurse, so arrangements may be made for the student's medical care. **If your student will need medication on this trip, the Authorization to Administer Medication must be completed and signed.**

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

Telephone numbers other than home or business where a designated caretaker may be notified:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Health/Accident Insurance \_\_\_\_\_ Policy No. \_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

Personal Dentist \_\_\_\_\_ Phone \_\_\_\_\_

**HEALTH INFORMATION**

***Does student have:***

Allergies (please list) \_\_\_\_\_

Asthma \_\_\_\_\_

Diabetes \_\_\_\_\_

Seizure Disorder \_\_\_\_\_

Other \_\_\_\_\_

Does Student require any special health care or diet? \_\_\_\_\_ yes \_\_\_\_\_ no

Explain \_\_\_\_\_

Does student take medicine on a regular basis? \_\_\_\_\_ yes \_\_\_\_\_ no

Explain \_\_\_\_\_

Does student have a chronic health condition? \_\_\_\_\_ yes \_\_\_\_\_ no

Explain \_\_\_\_\_

