

**BALTIMORE COUNTY PUBLIC SCHOOLS  
STUDENT HEALTH HISTORY  
OVERNIGHT FIELD TRIP/FOREIGN STUDY PROGRAM**

School Name:	Sponsoring Teacher:
Date(s) of Trip:	Destination:
Student Name:	Student Birth Date:
Parent/Guardian Name:	Home Phone No.: (____) _____ Work Phone No.: (____) _____ Cell Phone No.: (____) _____

**HEALTH HISTORY**

1. Is your child under the care of a health care provider for any health concerns?  
 Yes  No

If Yes, please list all health concerns:

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2. Does your child have a serious allergy to a food, insect sting and/or drug?  
 Yes  No

If Yes, please describe:

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3. List any medications vitamins and supplements that your child takes each day and all emergency or "as needed" medications\*:

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**HEALTH HISTORY, CONTINUED**

4. Does your child have any special dietary considerations? \*  Yes  No

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5. Provide any other important health related information about your child:

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**READ AND SIGN THE FOLLOWING:**

This health history provided in this document is correct so far as I know. I give permission for \_\_\_\_\_ to participate in all field trip activities, except as noted.

Authorization is hereby granted to release this information to appropriate school personnel and BCPS teacher chaperones who will be accompanying students on the above-referenced field trip.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*Any prescribed and/or over-the-counter medications and special diets **require** a physician's order. The parent must complete the attached *Request to Administer Medication/Treatments Form* (Rule 6800, Form L) and return it to the school nurse prior to the scheduled trip.