CULTURAL EXCHANGE STUDENT HEALTH HISTORY

_____ _____
Student Name Birth date

_____ _____
Address Home Telephone

_____ _____
Parent/Legal Guardian Name Home Phone Work Phone Cell Phone
E-mail_____

_____
Parent/Legal Guardian Name Home Phone Work Phone Cell Phone
E-mail_____

Person to be called in case of emergency if parent/guardian(s) cannot be reached:

_____ _____ _____
Name Relationship Telephone

_____ _____
Physician Telephone

List any health problem(s):

List any allergies (bee sting, medications, food etc.):

List any medications, including prescribed medications for allergies:

List any accessibility and/or health concerns that you have regarding this trip:

Any prescribed and/or over-the-counter medications must have a physician's order.
Complete the attached authorization to administer medication or treatment and return to school nurse or program coordinator.

I hereby consent to disclosure of the above information to the chaperoning teachers supervising my child on this cultural exchange.

_____ _____ _____
Activity Parent/Guardian Signature Date

CULTURAL EXCHANGE NOTIFICATION TO SCHOOL NURSE

Sponsoring School or Curriculum & Instruction (C&I) Office: _____

Principal or C&I Director: _____

Chaperoning Teacher(s): _____

Dates of Cultural Exchange: From _____To _____

Grades/levels of students participating in the cultural exchange: _____

List of student participants (attached):