BRIDGEWATER-RARITAN HIGH SCHOOL
P.O. Box 6569
BRIDGEWATER, NJ 08807
NURSES' OFFICE 908 231-8660 x 2242 FAX 908-253-3678

Student Last Name: ____________________________ First Name: ___________________Grade:_____
Parent/Guardian/ Last Name: ____________________First Name: ______________________________
Parent/Guardian/ Last Name: ____________________First Name: ______________________________
Parent/ Home Address ____
Best Contact #1 ____________________________ Best Contact #2_____________________________
Emergency Contact (in case parent/guardian) cannot be reached:
Last name: ____________________________________ First Name: _________________________
Relationship to Student: _____________________________ Phone Number: (____)_____________

Name of Primary Care Physician_____________________________ Phone: (____)_________________
Address: ____

List only medications that MUST be administered by the Nurse during the time frame of the trip.

Medication	Dose	Times Given	Condition Being Treated

Allergies your child has if any____
Carries Epipen YES_______ NO ________ Carries Inhaler YES_______NO________

Check each item to indicate whether or not your child has any of the following:
Asthma _____ Diabetes _____ Epilepsy _____ Chronic Condition______________________________

My child has my permission to participate in the trip and receive emergency medical treatment if required as a result of an injury or illness which may occur during this trip. All of the above information must be completed and signed by the parent/guardian.

Parent/Guardian Signature: _________________________ Date: _________________________

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