

**COLORADO SPRINGS SCHOOL DISTRICT 11 HEALTH INSURANCE AND MEDICAL INFORMATION FORM**

Student's Name \_\_\_\_\_

School **CIVA Charter School**

Destination **YMCA of the Rockies, Colorado**

Departure Date **Sep 13, 2022** Return Date **Sep 15, 2022**

Name of Health Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Name of Insured (Subscriber) \_\_\_\_\_

Insurance company's policy for obtaining treatment outside of the area or state.

\_\_\_\_\_

Does the insurance company require a certain form to be filled out in case of an emergency?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please provide the school with a copy of the form prior to departure.

***Please attach a copy (front & back) of the subscriber identification card on the above policy to this form.***

\_\_\_\_\_ Custodial Parent/Legal Guardian Signature

\_\_\_\_\_ Date

**MEDICAL INFORMATION**

Name of Doctor \_\_\_\_\_ Phone (Day) \_\_\_\_\_

Address \_\_\_\_\_ Emergency Phone \_\_\_\_\_

List all medications the student will bring or be required to take while on the above trip and specific written instructions from the physician and parent/guardian signature, for administration of **any** medication. **ANY MEDICATION MUST REMAIN IN ITS ORIGINAL CONTAINER.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any allergies, medical conditions, food restrictions or other conditions regarding the student's health which the staff might need to know about.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please understand that District 11 personnel cannot, by law, administer or provide any medications to your child without your permission and a physician's direction. Any and all authorized medication must be provided by you. If you authorize such thing in case of emergency complaints, please initial one of the below:

\_\_\_ (parent/guardian initials) I request that my child may receive over-the-counter-medication/s during the trip for non-emergency complaints. I understand that CIVA Staff is not responsible for any reaction that may occur as a result of my child's taking this OTC medication. Please signify your approval to administer these medications based on need & our judgment. The following may be given to my child & anything not circled will NOT be administered: Tylenol, Ibuprofen, Benadryl, Dramamine, Tums.

\_\_\_ (parent/guardian initials) I do not give permission for my student to be given any over-the-counter-medication/s