THE MONTESSORI ELEMNTARY AND MIDDLE SCHOOL

STUDENT TRAVELER INFORMATION FORM

(All pages of this document must be completed AND attached to the Student Travel Consent and Medical Release

Group / Destination: The Counties of the US, Poland & France.
Sponsor/Chaperone: Stanley Albrycht, Alissa Sanchez, & Sherry Haworth
Trip Dates: May 10th, 2017 thru May 25th, 2017 and extend if travel is delayed
Emergency Contact # while traveling (Sponsor Cell #, or other): Stan Albrycht 505-238-6258 Cell & Alissa Sanchez Cell 505-238-6432

Student Traveler Information

Student **FULL LEGAL NAME** (Last, First, Middle Name):
Date of Birth: Place of Birth (City, State):
Home Street Address:
City, State, Zip:
Home Telephone #: Student's Cell **#**:

Father (or Guardian)
Name:
Address (if different from student):
Phone: Cell #: Work #: Home#:
Email Address:

Mother (or Guardian)
Name:
Address (if different from student):
Phone: Cell #: Work #: Home #:
Email Address:

Emergency Contacts (if parents cannot be reached)
Name:
Relationship to student:
Phone#: Cell #: Work #: Home#:
Email Address:

Health Insurance Information (attach copy of Insurance Card with policy #)
Ins. Company Name: Ins. Company Phone #:
Policy Holder's Name:
Policy #: Group #:

Physician Information
Physician's Name:
Physician's Telephone **#**:

Medical Conditions (e.g. asthma, allergies, diabetes, ADHD, psycho-social)

_____
_____
_____

Over the Counter Medications to be administered by sponsor if needed (circle if allowed and provide appropriate dosage): Advil, Benadryl, Claritin, Dramamine, Imodium, Midol, Pepto-Bismol, Sudafed, Tums, Tylenol, (or generic equivalents) other:

Current Medications to be taken while on trip – *PARENT MUST DELIVER TO SPONSOR ON THE DAY OF DEPARTURE ALL MEDS IN A CONTAINER DISPENSED BY A PHARMACIST W/ PHYSICIAN'S DOSAGE AND ADMINISTRATION INSTRUCTIONS* ****

Name of medication (RX and OTC): ______________________________
Frequency, Dosage & Storage requirements: ______________________________
Who will dispense meds (student or chaperone)? ______________________________
Does student need to keep medication on his/her person? YES/NO. If yes, has student been instructed by a licensed medical care provider on the appropriate methods of self-administering the named medication? YES/NO.

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Frequency, Dosage & Storage requirements: ______________________________
Who will dispense meds (student or chaperone)? ______________________________
Does student need to keep medication on his/her person? YES/NO. If yes, has student been instructed by a licensed medical care provider on the appropriate methods of self-administering the named medication? YES/NO.

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Name of medication (RX and OTC): ______________________________
Frequency, Dosage & Storage requirements: ______________________________
Who will dispense meds (student or chaperone)? ______________________________
Does student need to keep medication on his/her person? YES/NO. If yes, has student been instructed by a licensed medical care provider on the appropriate methods of self-administering the named medication? YES/NO.

Student's Allergies (include medical, food, environmental, animal):
Allergy: ______________________________
Action to be taken (medication, or other): ______________________________
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Other health related information of which Sponsor's should be aware: ______________________________
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____

We/I have completed the forgoing Student Travel Information From and it is true and correct.

Parent's and/or Guardian's Signature: ______________________________

Date:______________________________

Parent's and/or Guardian's Signature: ______________________________

Date:______________________________

(ATTACHMENT TO "STUDENT TRAVEL CONSENT AND MEDICAL RELEASE")