Attachment B. for Board Policies: 241. Field Trips & 241.1 Overnight Trips

Bethel Park School District
Student Emergency Information Form
(to be used for all school related activities and field trips)

PLEASE PRINT ALL INFORMATION CLEARLY
Information is to be viewed only by District Professional Staff & Emergency Medical Personnel
FERPA and HIPAA Regulations Apply

Activity/Event Information: (Completion and submission of this form indicates permission for the student's participation in the activity identified below.)

Activity/Event _____ Date(s) of Activity _____

Student Information

Name _____ Date of Birth ___/___/___

Address _____ Home Phone ( )_____

Health Insurance Information

Insurance Provider _____ Provider's Phone # ( )_____

Agreement # _____ Group # _____

Name of Insured _____

First Aid/Emergency Treatment Authorization

In the event of an emergency where treatment is required, every attempt will be made to reach a parent or guardian. However, school district employees are authorized under *in loco parentis* to seek medical treatment and to share this information, when necessary, in the best interest of the student, with emergency medical personnel.

Parent/Guardian Information

Name: _____ Relationship _____ Phone( )_____

Name _____ Relationship _____ Phone( )_____

Name: _____ Relationship _____ Phone( )_____

Other Emergency Contacts

Name _____ Relationship _____ Phone( )_____

Name _____ Relationship _____ Phone( )_____

NAR/2007/ revised 9/13/07

Student's Health Information -Please check all that apply and explain as necessary

_____ Asthma	_____ Seizure Disorder	_____ Diabetes
_____ Heart Condition	_____ Fainting	_____ Low Blood Sugar
_____ Frequent Nose Bleeds	_____ Migraines	_____ Dietary Restrictions
_____ Vision Problems	_____ Glasses/Contacts (circle)	_____ Other (Explain below)

_____ Allergies List _____

Date of Last Tetanus Shot _____

List Medications: (Please note that District Staff will only administer meds for which a physician's prescription is on file. A doctor's note is also necessary for over the counter medications. Please attach the necessary documentation.) Student must turn in all medication (including over-the-counter meds) to District Staff. The School Nurse or other appropriate district staff will be responsible for securing and distributing medication.

Medication _____ Dosage _____ Frequency _____

Medication _____ Dosage _____ Frequency _____

Medication _____ Dosage _____ Frequency _____

Medication Allergies _____

Special Instructions/Explanations for health issues or medications listed above:

_____

_____

_____

(Use an additional page if needed for complete explanation.)

Name of Student's Physician _____ Phone( ) _____

Name of Student's Dentist _____ Phone( ) _____

Authorization of Parent/Guardian:

_____ _____

Signature Date

NAR/2007/ revised 9/13/07

Request for Medication Administration

Student's Name

The school physician has written orders for the school nurse to administer the following medications on the music department trip. Please **initial** all medications that you permit your child to take while on the trip. Please be aware that the nurse will carry a supply of each medication on this standing order list, but supplies may be limited.

_____ acetaminophen
_____ ibuprofen
_____ cold medicine
_____ cough drops
_____ diphenhydramine (Benadryl)
_____ meclizine (Bonine)
_____ dimenhydrinate (Dramine)

_____ antidiarrheals (imodium AD)
_____ antacids (Maalox, Tums, Mylanta)
_____ topical anesthetics (Chloraseptic)
_____ Calamine/Calahist/CalaGel/Caladryl
_____ PABA- free sunscreen

I understand fully the manufacturer's directions and agree to permit the school to administer this medication to my child. In consideration of the school district's agreement to use good faith efforts to properly administer this medication, the district is hereby relieved from liability for any failure to properly administer this medication. I also authorize the school to contact the physician regarding said medication.

Parent/Guardian Signature _____

Date _____

Phone Number (home/cell/work) _____

If your child requires any medication not listed above (prescription OR over the counter), a Medication Administration form, signed by your child's physician must be given to the nurse before the day of departure. Students are permitted to self-administer and carry all medications with the exception of barbiturates, narcotics and psychotropics. The school nurse is responsible for securing and administering these medications. These medications should be provided to the nurse in the original pharmacy container with only the amount necessary for the trip.

My child has the following dietary restrictions:

_____ Vegetarian (can eat dairy)
_____ Vegan (no dairy)
_____ Gluten Free
_____ Kosher
_____ Lactose Intolerant
_____ Food Allergy (Please list) _____
_____ None of the above

BETHEL PARK SCHOOL DISTRICT

BETHEL PARK, PENNSYLVANIA

REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

The Bethel Park School District requests that medication be administered at home during non-school hours. We do, however, recognize that sometimes it is essential for medication to be administered at school. No prescription or "over-the-counter" medications will be given to any student without an order from a physician, along with signatures from the physician and the parents/guardian. All "over-the-counter" medication MUST be in the original manufacturer's container with the student's name written on the container. All prescription medications MUST be in a pharmacy labeled container. The pharmacy labeled container must include the name and phone number of the pharmacy, the name of the student, the physician's name, the name of the medication, the currently prescribed dose, time of administration and the Rx number.

Prescription medication in a pharmacy labeled container dated within the last 2 weeks and to be administered for NO MORE THAN 10 SCHOOL DAYS requires a parent's/guardian's signature & the completion of the information below. Medication prescribed for longer than 2 weeks also requires a physician's signature.

Student's Name: Last First Grade Age

Physician's Name (print) Phone Number

I understand fully the directions that have been given to the school by the physician and agree to permit the school to administer this medication to my child. In consideration of the school district's agreement to use good faith efforts to properly administer this medication, the district is hereby relieved from liability for any failure to properly administer this medication. I also authorize the school to contact the physician regarding said medication.

Date Parent/Guardian Signature Phone Number (home/cell/work)

TO BE COMPLETED BY THE PHYSICIAN:

Name of Medication:
Diagnosis (reason medication is prescribed):
Dose: **Route:**
If medicine is to be given "when needed" describe indications:
If medicine is to be given daily, at what time?
How soon can it be repeated?
List Significant side effects:
Length of time treatment is recommended:

Other Information

Date Physician's Signature