GLENWOOD MIDDLE SCHOOL BAND

IFAS 39502236

EXTENDED DAY AND OVERNIGHT FIELD TRIP AND FOREIGN TRAVEL EMERGENCY PROCEDURE/HEALTH INFORMATION

MUST BE COMPLETED BY PARENT FOR ANY STUDENT ATTENDING TRIP

STUDENT'S NAME _____ MALE_____ FEMALE_____

LAST NAME FIRST NAME MIDDLE INITIAL

SCHOOL _____ GRADE _____ DATE OF BIRTH _____

STREET ADDRESS _____

CITY _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

FAMILY PHYSICIAN _____ PHONE _____

PARENT/GUARDIAN NAME _____

EMERGENCY NOTIFICATION

(List in order of Notification - Parent/Guardian will be contacted first unless otherwise specified.)

MAJOR EMERGENCIES WILL BE TAKEN TO THE NEAREST HOSPITAL

_____

NAME OF PERSON RELATIONSHIP PHONE NUMBER

_____

NAME OF PERSON RELATIONSHIP PHONE NUMBER

HEALTH INFORMATION

(Please list & give dates if known)

Health conditions/operations:

Handicapping Conditions:

Allergies (medication, food, insects, etc.):

Describe the usual **symptoms/reactions**:

Medications (prescription and non-prescription):

For any daily medication that may be needed outside regular school hours, a separate written order form from the physician/prescriber and medication from home must be provided. For daily medications needed during the school day and any as needed medication on file in the health room, the School Nurse/Health Assistant will provide copies of existing medication orders and medication for use. There will not be a school nurse in attendance on this trip.

Does your child have any activity restrictions? Yes_____ No _____ if yes, please explain _____

Does your child have dietary restrictions? Yes_____ No _____ If so, what are restrictions? _____

INSURANCE COMPANY _____ POLICY OR BINDER NUMBER

_____

PERMISSION IS GRANTED FOR TREATMENT OF THE ABOVE NAMED PARTICIPANT BY A PHYSICIAN AND/OR HOSPITAL FOR ANY MEDICAL OR SURGICAL EMERGENCY.

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

The information you provide will be handled in a confidential manner. Information provided on this form will be shared with staff as necessary to maintain your child's safety

EXTENDED DAY AND OVERNIGHT FIELD TRIP AND FOREIGN TRAVEL MEDICATION/TREATMENT ORDER

MUST BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER ONLY IF MEDICATIONS/TREATMENTS ARE REQUIRED ON TRIP

Dear Health Care Provider:

Your patient will be participating in an approved trip to _____ from _____ to _____There will not be a school nurse in attendance on this trip.
(Date & Time) (Date & Time)

If you have any concerns about your patient's health needs on this trip, please contact the nurse at _____. Please indicate below any treatment/prescription and/or over-the-counter medications that your patient is currently taking and will need to continue to take while on the trip. This form must be returned two weeks prior to the trip date to provide for planning and staff training.

_____ _____
Student's Name Date of Birth

No medication/treatment can be administered without physician authorization.

To be completed by Physician:

Medication/Treatment	Dosage/Frequency of Administration	Circumstances/symptoms for administration	Diagnosis	Student may carry & self-administer medication. (please check)

Health Care Provider Signature: _____ Date: _____
Parent Signature: _____ Date: _____

FOR OVERNIGHT AND FOREIGN TRAVEL FIELD TRIPS: If prescription or over-the-counter medication is needed, a separate written order from your physician/prescriber is required. Refer to attached Medication/Treatment Order Form. MEDICATION MUST BE PROVIDED FROM HOME. There will not be a school nurse in attendance on this trip.

To be completed by School Personnel:

Medication/Treatment	Date/Time Medication Given	Date/Time Medication Given	Date/Time Medication Given	Signature of Designated School Personnel