Field Trip Travel Permission And Medical Information

Staff Use Only:
Allergies: _____
_____
Asthma Inhaler: _____
Epi Pen: _____

Campus:_____

Org. _____

Academic Year:_____

Student Name: _____ Age: _____ Male/Female
(Last, First) (Circle One)
Date of Birth: _____/_____/_____ Instrument: _____ Grade: 6/7/8

Parent/Guardian:
Name(s):_____

E-mail: _____

Full Address: _____
Phone Number(s): Please list all where you can be reached…
Phone Number(s): H(_____)_____ Wk (_____)_____ Cell (_____)_____

Emergency Contact: (Other than parent/guardian.)

Name: _____ Relationship: _____

Full Address: _____

Phone Number(s): H(_____)_____ Wk (_____)_____ Cell (_____)_____

Medical Information:

Doctor's Name: _____ Phone Number: (_____)_____

Health Insurance Carrier: _____

Policy Holder Name: _____ Policy #:_____

Physical History:

List special medical problems: (asthma, diabetes, allergies/anaphylaxis, seizures etc.): _____

_____

_____

List any known allergies to food / medications etc:_____

Does participant carry medications on person?(if so please state):_____

_____

Does your child have a medical condition which requires prescription medication to accompany and possibly be administered, on school sponsored trips? _____ Yes / _____ No
If yes, please complete the Prescription Medication Authorization Form.

Permission:

In the event of an injury/illness requiring medical attention, I hereby grant permission to the supervising teacher and/or staff (including volunteers/chaperones), to attend to my son/daughter. If the injury/illness requires further medical attention, I expect every effort will be made to contact me to receive my specific authorization before action is taken. If efforts to contact me are unsuccessful, I grant permission for further necessary medical treatment to be given. In addition, I also give my permission for the supervising teacher and/or staff (including volunteers/chaperones), to transport my child to the physician, dentist, clinic, or to the hospital if an accident or serious illness occurs on the trip and I cannot be located. I understand that treatment will not be delayed in the event I cannot be contacted. I understand and agree that I, and/or my child's other parent(s)/legal guardian(s), am responsible for all medical expenses incurred in treating my child.

_____ _____

Signature of Parent Date

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

Student Name: _____

(Last, First)

Non-Prescriptions/Over-the-counter (OTC) Medication Authorization:

I give Pflugerville ISD representatives, including staff and volunteer chaperones, permission to administer "over-the-counter" medications including, but not limited to, the following medications, at the request of my child. I understand that PfISD personnel will not administer medications if this form is not complete.

_____ I **DO NOT** give consent to staff to administer any non-prescription medication to my student.

_____ I **DO** give consent to staff to administer non-prescription medications to my student as initialed below:

Please *initial all approved* medications that can be administered:

_____ Ibuprofen _____ Acetaminophen _____ Antihistamine

_____ Anti-Diarrheal _____ Antacids _____ Cough Drops

_____ Antibiotic Ointment (topical for cuts and/or scrapes) _____Hydrocortisone Cream (for topical itch/rash relief)

Is your child allergic to topical antibiotic ointments? Yes/No

"Over-the-counter" medication NOT to be given to my child include: _____

_____

Parent Signature: _____ *Date:*_____

PfISD

Student Name: ____

(Last, First)

Prescription Medication Authorization:

I request that a PfISD representative, including staff and volunteer chaperones, administer the following medication to my child according to the physician's instructions while on this field trip. I agree to furnish an adequate amount of medication in the original container at the time of travel. **All medications must be in their properly labeled containers with name, dose, frequency of administration clearly noted.** Students may only self administer inhalers and epi-pens with the appropriate forms on file with the district, and must be signed by a their physician and prescription labels must be current. As needed (or PRN) medications should have the frequency of repeat doses indicated on the orders. ***Expired medications cannot be given.*** *A second labeled container can be obtained by asking your pharmacist*. Attach another sheet of paper if necessary to continue with medications. ***The first dose of any new prescription medication must be given at home.***

Medications

Medication Name: ____________________________ Dosage:____________ Time: ____________

Parent notified: _______________

Reportable side effects: ____

Date														
Time/Initial														

Medication Name: ____________________________ Dosage:____________ Time: ____________

Parent notified: _______________

Reportable side effects: ____

Date														
Time/Initial														

Medication Name: ____________________________ Dosage:____________ Time: ____________

Parent notified: _______________

Reportable side effects: ____

Date														
Time/Initial														

***Administered by staff/chaperones/volunteers on the trip*

____

Admin. Signature /Initials

PFISD

Medications (cont.)

Student Name: ____
(Last, First)

Medication Name: ____________________________ Dosage:____________ Time: ____________
Parent notified: _______________
Reportable side effects: ____

Date														
Time/Initial														

Medication Name: ____________________________ Dosage:____________ Time: ____________
Parent notified: _______________
Reportable side effects: ____

Date														
Time/Initial														

Medication Name: ____________________________ Dosage:____________ Time: ____________
Parent notified: _______________
Reportable side effects: ____

Date														
Time/Initial														

Medication Name: ____________________________ Dosage:____________ Time: ____________
Parent notified: _______________
Reportable side effects: ____

Date														
Time/Initial														

____
Admin. Signature /Initials

****Administered by staff/chaperones/volunteers on the trip***