HS FORM #28

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

HEALTH INFORMATION FOR FIELD TRIPS

Student Name: _____ Social Security # (optional): _____
Home address: _____ Date of Birth: _____
Homeroom: _____ Grade: _____ Age: _____ Male: ___ Female: ___
Destination of Trip: _____ Date(s) of Trip: _____
Trip Advisor/Teacher: _____
Emergency Contact Person(s)*:
1. Mother/Guardian: _____ Home phone: _____
   Work phone: _____ Cell phone: _____
2. Father/Guardian: _____ Home phone: _____
   Work phone: _____ Cell phone: _____
3. Other Contact person: _____ Home phone: _____
   Work phone: _____ Cell phone: _____
4. Physician Name: _____ Phone: _____

** Please make sure these persons CAN BE REACHED THE DAY(S) OF THE TRIP.*

Does your student have Health Insurance? ___ Yes ___ No

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Is there any health-related condition or medication which may need special consideration during the field trip? ___ NO ___ YES (please specify below)
Condition/medication(s):

_____

- *If there is a significant health-related condition which may need special consideration during the field trip, please make every attempt to be a trip chaperone. If student's safety cannot be arranged and assured, student may not be able to attend.*
- *Students are allowed to self-administer asthma inhalers, injectable epinephrine, or other medication for a life-threatening condition providing there is physician and parent permission on file for the current school year. Contact the school nurse for appropriate district forms to be completed.*
- *ALL MEDICATIONS (prescription and over-the-counter) require current physician order and parent permission on file. Medication MUST be in original labeled container or packaging. Contact school nurse for district medication administration form.*
- *CONTACT THE SCHOOL NURSE IMMEDIATELY IF ANY HEALTH CONCERN.*

Is there any reason that your student may not participate fully in the field trip activities?
___ NO ___ YES (please specify below)
Explain limitation(s): _____

PARENT/GUARDIAN AUTHORIZATION:

The above information is correct to the best of my knowledge, and my student can engage in all field trip activities unless noted above. In case of emergency and I cannot be reached, I give permission to the physician or hospital selected by the school representative to secure proper treatment and medical care (e.g. medication, anesthesia, surgery, etc.) in case of emergency or as specified above for my student.

_____ _____
Signature of Parent/Guardian Date

HEALTH HISTORY UPDATE:

Please check YES or NO for the following health information concerning your student. Be sure to include any recent (past 6-12 months) injuries, illnesses, or surgery that is in the student's health history which could influence their class trip activity participation or needs.

	Yes	No	Specifics
Allergy (environmental, food, medication, etc.)	___	___	_____
Arthritis/joint or bone condition	___	___	_____
Asthma/Reactive Airway Disease	___	___	_____
Bleeding/blood disorder	___	___	_____
(eg: anemia, hemophilia, sickle cell disease, etc.)			
Communicable disease/condition or recent exposure	___	___	
_____			
(eg: strep, head lice, chicken pox, pink eye, impetigo, ringworm, etc.)			
Developmental condition/consideration	___	___	_____
(eg: ADHD, Down's Syndrome, Autism, brain injury, etc.)			
Diabetes	___	___	_____
Digestive/stomach condition	___	___	_____
Dental/orthodontic appliance or other prosthesis	___	___	_____
Eyeglasses/contacts/vision loss	___	___	_____
Fainting/lightheaded episodes/heat sensitivity	___	___	_____
Hearing loss	___	___	_____
Heart condition or chest pain with exercise	___	___	_____
High blood pressure	___	___	_____
Seizure disorder	___	___	_____
Immune system disorder	___	___	_____
(eg: mono, chronic fatigue syndrome, chemotherapy, etc.)			
Menstrual disorder/difficulties	___	___	_____
Significant fears/phobias	___	___	_____
Sleepwalking or sleep time difficulties	___	___	_____
Toileting considerations	___	___	_____
Orthopedic condition, recent injury, back pain	___	___	_____
Other (please specify)	_____		
Date of most recent tetanus shot, if known	_____		

Please specify any dietary needs:

___ Vegetarian ___ No milk/dairy ___ Food allergy ___ Other

** Some conditions above may require specific physician clearance to participate.

rev. 9/00, 12/02, 10/03, 2/04, 4/09

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HEALTH SERVICES

MEDICATION FOR OVERNIGHT TRIPS/ACTIVITIES

Dear Parent/Guardian:

The following over-the-counter medications are covered under the orders of the Edison Township district school physician. These medications may be given by the designated district nurse *only* if needed during overnight trips or activities. They will be administered ONLY according to the labeled indication(s) and dosage(s).

Please place an "X" next to the specific over-the-counter medication(s) you want given to your child if needed during the trip/activity time only.

Over-the-Counter Medications

___ ibuprofen (eg: Advil)

___ acetaminophen (eg: Tylenol)

___ loperamide (eg: Imodium AD)

___ diphenhydramine (eg: Benadryl)

Student: _____ Grade: ____ School: _____

I hereby give my permission for the designated district nurse to administer to my student, the medications marked by an "X" above. I understand that these medications may be given ONLY according to the labeled indication(s) and dosage(s), as per the current Edison Township district school physician order.

I release school personnel of all liability for the administration of medication as specified above, during the trip/activity date(s): _____ (specify dates).

_____ _____

Signature of Parent/Guardian Date

****ALL OTHER MEDICATIONS NEED PHYSICIAN ORDER & PARENT PERMISSION ON FILE WITH THE SCHOOL NURSE TWO WEEKS PRIOR TO TRIP/ACTIVITY START.**

****All labeled container medications must be submitted to the school nurse minimally TWO SCHOOL DAYS PRIOR to the day of the trip or activity.**

Rev. 9/01, 10/03, 2/04, 4/09, 5/12, 5/13

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MEDICATION ADMINISTRATION PERMISSION

Dear Parent/Guardian:

All medication, prescription or OTC (over-the-counter) shall be administered only upon written order of the prescribing physician and a written request of the parent. This will give permission for the nurse to administer the medication as directed.

Medication must be given to the nurse **only** in a **currently** labeled prescription bottle or OTC labeled packaging.

PLEASE REVIEW THE ENTIRE MEDICATION POLICY #5330 ATTACHED (TWO PAGES).

TO BE COMPLETED BY PHYSICIAN

Student: _____ *Date:* _____ *School Year: September* _____ *to June* _____

Diagnosis/Purpose: _____

Name of Medication: _____

Dosage: (mg) _____

Specific time(s) to be given: _____ **(Daily or PRN) (circle one) am / pm**

Special circumstances of administration **(if PRN, specify frequency)**: _____

Dates of Administration: _____

Specify **reportable** side effects: _____

_____ _____
Name of Physician **(print)** Signature of Physician

_____ _____
Address of Physician Date

(_____)_____
Telephone # of Physician

TO BE COMPLETED BY PARENT/GUARDIAN

Student: _____ *Date:* _____

I hereby give permission to the school nurse to administer medication to my child as directed by the physician.

I release school personnel of all liability for the administration of medication as specified above.

_____
Signature of Parent/Guardian

_____
Date

8/96,5/98,2/99,6/99,4/02,4/03,2/07,9/07
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