

Bellevue School District
Procedure 2320P Exhibit E

Out of State or Overnight Field Trip Emergency Health Form

To be filled out by the parent/guardian of the student attending the out of state or overnight field trip or camp and returned to the BSD employee responsible for the trip no later than: _____.

Student Name: _____

Student Birthdate: _____

Student BSD ID# _____

Parent/Guardian Name: _____

Home address: _____

Phone: Home: _____

Work # (Parent 1) _____

Cell #: _____

Email address: _____

Work # (Parent 2) _____

Cell #: _____

Email address: _____

Name, phone number, and email address of two emergency contacts if the parent/guardian cannot be reached (relatives, close friends). These people may provide information regarding where the parent/guardian might be reached, or they might be asked to give advice/permission for medical care. **Please notify these individuals that their names have been given for this purpose.**

1) Name: _____

2) Name: _____

Phone: _____

Phone: _____

Email: _____

Email: _____

Permission for Emergency Medical Treatment

In the event that I/we cannot be contacted to authorize emergency medical treatment for _____ (*student name*) during his/her participation in the camp/field trip, the Bellevue School District staff member in charge of medical care has my permission to authorize emergency medical treatment. I also give permission for school staff to transport my child to a medical treatment center if needed.

Signature of parent/guardian _____ Date: _____

Needed in case of emergency:

Name of insurance company: _____

Name of Subscriber: _____

Policy # _____

Student Name: _____	Student BSD ID# _____
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Health Information: The following health conditions can be of concern. If your child has one or more condition, please describe.

Condition	Please Describe What Happens
Abnormal Bleeding	_____
Allergies	_____
Please circle type of allergy: foods, insects, medication, environmental, other	_____
Diabetes	_____
Heart/circulatory problems	_____
Seizures	_____
Intestinal problems (Including frequent stomach aches, constipation, diarrhea, indigestion, etc.)	_____
Respiratory problems (including asthma, bronchitis)	_____
Urinary problems (including bed wetting)	_____
Other, please indicate	_____

Is your child physically able to take part in all trip activities? Yes No

If No, what limitations are needed? _____

Will your child need to take medication on the trip, such as daily medications and/or as needed medications such as inhaler, pain reliever or allergy medications? Yes No

If Yes, please follow these steps:

- All medications (prescription or over-the-counter) need to have a medication authorization form signed by a doctor and a parent (Please see [3416P Exhibit A – Medication Authorization Form](#)).
- The completed medication authorization form must be attached to this permission form for review by the school nurse.
- If your child is able to self-carry or self-administer, the medication authorization form still needs to be signed and attached.
- If the trip is within Washington state, the medication authorization form will be kept and medication will be given by a BSD employee who is supervising the trip. If the trip is outside Washington state, please speak with the school nurse as soon as possible.
- Prescription medication must be sent in the original pharmacy container. Over-the-counter medication must be sent in the original retail container with student’s name, dosage, and time to be given.

I have reviewed and understand the above information:

Parent Signature: _____

Date: ~~12.18.17~~, 5.8.24