GREAT MEADOWS MIDDLE SCHOOL
MEDICAL INFORMATION – OVERNIGHT TRIP FORM

I. STUDENT INFORMATION:

NAME:	Home Phone #:
Address:	Birth date: ____/____/____

II. PARENTAL INFORMATION: PHONE #'s with area codes

Father/Guardian's Name:	Cell #:
Employer's Name:	Home #:
Employer's Address:	Employment #:
Mother/Guardian's Name:	Cell #:
Employer's Name:	Home #:
Employer's Address:	Employment #:
Physician:	**Physician #:**

III. ALTERNATIVE EMERGENCY CONTACT: PHONE #'s with area codes

1st. Contact: Name:	Home #:
Address:	Cell #:
Relationship:	Employment #:

V. HEALTH INFORMATION:

Answer all questions with pertinent information or the word NONE. **Leave no questions unanswered.**

1.) **Allergies**:

2.) **Daily Medications**(including names of evening and morning medications):

3.) **Dietary Concerns** or restrictions/ Food allergies: i.e. milk sensitivity

4.) **Health Concerns**/history: i.e. asthma, anemia, anorexia, etc.

5.) **Recent Traumatic Events**: i.e. fractures, serious accidents, etc.

6.) Has your child been **exposed to any communicable disease**(s) within the past twenty-one days? If yes, what? (i.e. Strep., mono, chicken pox)

7.) Night terrors or sleep problems:

Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity (heart, recent fractures or surgery, asthma, etc?) If yes, please specify:

Do you have other concerns?

IV. PERMISSION FOR ADMINISTERING MEDICINE:

Prescription Medications: (only for **absolutely necessary** medications, no vitamins, herbals, etc.)	
1. Medication:	Condition Requiring Medication:
Dosage:	Administration Times:
2. . Medication:	Condition Requiring Medication:
Dosage:	Administration Times:
3. . Medication:	Condition Requiring Medication:
Dosage:	Administration Times:

Prescribing Healthcare Practitioner: _____ Phone #: _____

"Administration of Medication" forms and a pharmacy labeled medication container MUST be submitted ASAP – no later than MAY 20, 2016.

These Over-the-Counter medications may be dispensed to your child for minor acute health concerns.
Check the boxes ☑ next to the medication you are granting permission for the nurse to administer to your child if they present with a minor acute health need. Dispensing of medication is by product recommended dosages.

❑ **Tylenol** (acetaminophen)	❑ **Benadryl** (diphenhydramine HCL)	❑ **Imodium** (loperamide HCL)
❑ **Advil/Motrin** (ibuprofen)	❑ **Pepto Bismol** (bismuth subsalicylate)	❑ **Tums** (calcium carbonate)
❑ **Dramamine** (Dimenamine)		

NO over-the-counter medications (other then those listed above) **or prescription medications will be dispensed without written consent from your child's private healthcare practitioner.**
(See the nurse's web site for medication forms.)

Parent/guardian signature: ✍

VI. EMERGENCY CARE AND ADMINISTRATION OF MEDICATION AUTHORIZATION:

1. I, as the legal parent/guardian of the below named child/student, hereby consent to and authorize the nearest hospital or healthcare facility and its physicians in charge of my child's care, to perform emergency treatment and/or diagnostic procedures as deemed necessary or advisable. Additionally, I understand that every attempt will be made to notify me if emergency care is needed for my child.

2. I acknowledge that the Great Meadows School District and its employees shall incur no liability as a result of any injury arising from any healthcare provided and or the administration of prescribed medication(s) or health care and that we indemnify and hold harmless the school district and its employees or agents against any claims arising out of the administration of medication(s) or health care.

✍ **Child/Student's name:** _____

Insurance Co. _____ **Policy #:** _____

Parent/Guardian print name: _____

Parent/Guardian signature: _____ Date: _____