BETHLEHEM AREA SCHOOL DISTRICT
Bethlehem, Pennsylvania

MEDICAL INFORMATION FORM
to be completed by ALL students for overnight trips

PRINT clearly:

Student name ____
(Last) (First) (Middle Initial)

Address ____

School/Building ______________ Grade ________ Date of Birth __________ Age ________

Trip Destination ____

Dates of Trip ____

Person to be notified in an emergency:

Name ____

Relationship ____

Contact # ______________________ Alternate # ______________________

Primary Physician Information:

Name ______________________ Phone ______________________

Address/City/State ____

Insurance Information:

Company Name ____

Insured ID# ______________________ Group# ______________________

Primary Subscriber ______________________ Prescription Plan ______________________

List allergies to food, medication, animals, etc. If NONE, please state:

____

List any special medical problems. If NONE, please state:

____

____

I/We understand that all valid releases, authorizations, and insurance information provided previously to the District apply to this trip. I/We authorize any necessary medical treatment to this student while participating in the activities associated with this trip. I/We guarantee reimbursement of all charges incurred if medical treatment (physician, hospital, x-ray, labs, drugs, ambulance, etc.) is necessary.

______________________ ______________________
Parent/Legal Guardian Date Parent/Legal Guardian Date

COMPLETE SECTION B REGARDING MEDICATIONS ON REVERSE SIDE

SECTION B

to be completed by ALL students for overnight trips if a nurse is attending

Student's name ____

The medications listed below will <u>ONLY</u> be administered by the nurse to your child if you, as the parent/guardian, indicate your intent and provide your authorized signature. A check mark (√) must appear on each line of the chart below.

<u>Medical Abbreviations</u>: P.O. = by mouth P.R.N. = as necessary
q = every B.I.D. = 2 times

			ALLOWED	NOT ALLOWED
1.	Acetaminophen	1 tablet 325 mg for student 11 years or younger and 2 tablets for student 12 years or older P.O. q 4 hrs. P.R.N. for fever over 101°, headache or pain		
2.	Ibuprofen	60 -71 lbs 250 mg, 72 – 95 lbs 300 mg and over 96 lbs 400 mg P.O. q 6 hrs. P.R.N., for fever of 101°, headache or pain		
3.	Antacid (Tums)	2 tabs P.O. at onset of indigestion sour stomach P.R.N. No more than 6 tablets in 24 hours.		
4.	Throat Lozenge	1 lozenge P.O. q 2 - 3 hr., P.R.N. throat irritation		
5.	Benadryl	25 mg P.O. q 6 hrs. hives, itching, mild allergic reactions P.R.N.		
6.	Bacitracin Ointment	apply topically B.I.D. to minor wounds P.R.N.		
7.	Anbesol	apply topically q 2 - 3 hrs. P.R.N. for tooth pain		
8.	Solarcaine	apply topically B.I.D. to unbroken skin P.R.N. sunburn		
9.	Sudafed	1 tab 30 mg P.O. every 6 hrs. for nasal congestion age 11 and older		
10.	Robitussin DM	2 tsps. P.O. every 4 hrs. for cough		
11.	Claritin	10 mg P.O. once daily for mild respiratory allergies		
12.	Dimenhydrinate	1-2 50 mg tablets P.O. every 6 to 8 hours as needed for motion sickness		

I/We authorize the assigned nurse attending this trip to administer the above medications to my child.

______________________________ ______________________________

Parent/Legal Guardian Date Parent/Legal Guardian Date

cmp-halkins-7-23-19

BETHLEHEM AREA SCHOOL DISTRICT
Bethlehem, Pennsylvania

Authorization Form - Self Medication - Overnight Trips Accompanied by a Nurse - High School Only
(to be completed by parents/guardians)

Dear Parent or Guardian,

You have indicated that your child requires the administration of medication(s) during an overnight educational trip/activity. It is recognized that some students may have unique medical needs, and there may be instances in which medication will be required during an overnight school trip/activity. Administration of medication (including self-administration) is only <u>required</u> where one or more of the following criteria are met:

a. The student's physician has certified, in writing, that failure to take the medication would pose a health risk to the student;

b. The medication has been deemed to be a reasonable disability-related accommodation pursuant to the student's Section 504 plan or IEP; and/or

c. The student's physician has certified, in writing, that the student would be unable to participate in the program without the medication.

In circumstances other than those referenced above, the school nurse will make a determination as to whether a particular medication will be permitted to be administered on an overnight field trip.

Your child's medication will be administered pursuant to the information, below. Please sign this document and return it along with the required Certification/Order from your child's licensed healthcare provider to the school nurse by ________________________. If you have any questions, please feel free to contact the school nurse.

The District will proceed as follows with regard to the administration of your child's medication on the <u>[INSERT NAME OF EDUCATIONAL TRIP/ACTIVITY]</u>, which will take place on <u>[INSERT DATE(S) OF TRIP/ACTIVITY]</u>.

POSSESSION OF MEDICATION

The Student ☐ **IS** permitted to **POSSESS/CARRY** the medication during the trip. Such medication must be maintained by the student in a secure location. Misuse of medication or provision of medication to other individuals shall result in discipline and may result in the student's removal from the trip/activity.

The Student ☐ **IS NOT** permitted to **POSSESS/CARRY** the medication during the trip. The medication will be **MAINTAINED** by:

☐ Nurse
☐ Parent

ADMINISTRATION OF MEDICATION

Medication will be **ADMINISTERED** by:

☐ Student Self-Administration (Nurse: complete "Self-Administration" section, below)
☐ Nurse (A written order from a doctor will be required)
☐ Parent

SELF-ADMINISTRATION

☐ This student **is authorized** to self-administer his/her medication during the educational trip/activity on ______-______________. Note that the medication(s) identified in the attached Certification/Order must be presented to a school nurse prior to the beginning of the trip. Such medication must be provided in the original container with a valid expiration date. Only the amount of medication necessary for the trip should be supplied (an extra dose may be provided if the Parent or School Nurse feels that it would be prudent to do so).

☐ Self-administration **is not permitted** for this student. Reason: ____________________________.

The School nurse will review this information if it is determined a student may not self-administer the medication the parents/guardian will be contacted

Name of Medication(s) *(attach additional sheet, if necessary)*

Medication(s)	Dosage Amount	Reason for Medication(s)	Hour(s) or Time(s) to be Dispensed

☐ ***Check here if additional sheet is attached***

Name of Trip/Activity: ____

School/Building Activity will be taken with: ____

Dates of Trip/Activity: **From** ________________ **To** ________________

PARENT CERTIFICATIONS

By signing below, I certify that:

- I am the lawful parent/legal guardian of this student.
- The above chart accurately reflects the medication(s) being taken by my child.
- I agree with the above-identified information and procedures for administering medication to my child.
- Administration, self-administration, or possession of medication that is not medically necessary and/or does not meet the requirements set forth in Board Policy 210 – Administration of Medications shall not be permitted.
- I understand that any/all use and/or possession of medications by a student on school grounds or during a school-sponsored trip must comply with Board Policy 210 – Administration of Medications unless otherwise specified in my child's IEP or Section 504 plan.

- I understand that if my child is found to be in possession of medication that he/she has not been pre-approved to possess, pursuant to Board Policy 210 – Administration of Medications, such possession shall be considered a violation of board policy. I understand that students authorized to self-administer and/or carry medication assume full responsibility for appropriately securing the approved medication(s) and any improper use and/or distribution will result in disciplinary action.

(Where Parent will be attending the trip and has volunteered to administer the child's medication):

- I acknowledge that I have volunteered to administer my child's medication on this trip. I recognize that the District would make arrangements to ensure effective administration of my child's medication in the event that I had not volunteered. I further recognize that, in the event that I am not able to attend the trip, I need provide the District with as much notice as possible, so that the District can make alternate arrangements for the administration of medication. In the event that I am not able to provide at least 48 hours' notice of my non-attendance, and, as a result, the District is unable to make alternate medication administration arrangements for my child and/or unable to obtain the necessary approvals and certifications for self-administration, the District may be required to prohibit my child from attending due to medical concerns.
- I will indemnify and hold harmless the Bethlehem Area School District, including its Board of School Directors, employees and agents, against any claims arising out of the administration or self-administration of medication pursuant to this Authorization.

SIGNATURES

____
Parent/Guardian – Print Name Legibly

______________________________ _______________
Parent/Guardian – Signature Date

____
Student – Print Name Legibly

______________________________ _______________
Student – Signature Date

____
School Nurse – Print Name Legibly

______________________________ _______________
School Nurse - Signature Date

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