Dublin City School District

Program
2340C F1

Revised 8/29/13

District-Sponsored Overnight Trips
Medical Permission Form

- Upon central office approval of a district-sponsored overnight trip, the teacher in charge should distribute this form to all participating students.
- Parent/guardian is to read and complete this form, have it notarized, and return it to the teacher in charge of the trip. **Incomplete or non-returned forms shall result in the student being excluded from participation.**
- The teacher in charge of the trip shall take all completed forms on the trip for medical emergencies.
- All requests to administer prescription medication require an Ohio health care prescriber's signature.

Student's name: _____ Sex: _____ Birthdate: _____

Home address: _____ City: _____ Zip: _____

Mother/guardian's name: _____

Phone (H): _____ (W): _____ (Cell or Pager): _____

Father/guardian's name: _____

Phone (H): _____ (W): _____ (Cell or Pager): _____

EMERGENCY NUMBERS (if parent/guardian cannot be reached):

1. Name: _____ Phone (H): _____

Relationship to student: _____ Phone (W): _____

2. Name: _____ Phone (H): _____

Relationship to student: _____ Phone (W): _____

Student's health care provider: _____ Phone: _____

Medical insurance company: _____ Group No.: _____

Insurance company address: _____

Name of policy holder: _____ Identification/Policy No.: _____

If you have insurance, please attach a copy of the front and back of your insurance card to this form.

GENERAL HEALTH CARE INFORMATION

Please provide a copy of most current immunization record with <u>Tetanus circled</u>.

If your child was recently hospitalized, has a fracture or needs specific medical care, please attach written health care provider instructions to this form.

Please check all that apply to your child.

☐ Animal Allergies	☐ Poison Ivy allergy	☐ Activity restrictions	☐ Heart problem
☐ Bee/Insect Allergies	☐ Bleeding problem	☐ Dietary restrictions	☐ Migraines
☐ Drug Allergies	☐ Mobility concerns	☐ Asthma	☐ Glasses/contacts
☐ Environmental Allergies	☐ Sleep walking	☐ Seizures	☐ Ear infections/aids
☐ Food Allergies	☐ Bed wetting	☐ Diabetes	☐ Other _____

Please describe any medical condition including severity and treatment. _____

_____

_____

NONPRESCRIPTION MEDICATIONS

Students in high school only may self carry their nonprescription medications with a parent's permission. If not, these and all elementary and middle school nonprescription medications for overnight trips will be kept with the student's assigned teacher. All nonprescription medications must be brought to school in the original package or bottle of purchase.

Name of drug	Dose	Time(s) to be given	Side effects

My high school student may self carry the above listed nonprescription medication: YES ___ NO ___

PRESCRIPTION MEDICATIONS

IF YOUR CHILD TAKES ANY PRESCRIPTION MEDICATION, THE NAME OF THE DRUG, THE TIMES TO BE GIVEN, AND THE DOSE MUST BE FILLED OUT AND SIGNED BELOW BY YOUR HEALTH CARE PRESCRIBER.

If your child requires additional prescription medication after this form has been turned in, you must have a note signed by the health care provider to accompany the new medication, including the dose and times to be given. **ALL MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACIST.** Prescription medications, except inhalers and EpiPen as noted, must be turned in to the teacher in charge of the trip, the day of the trip.

The following information is to be completed and signed by an Ohio licensed health care provider:

Name of drug	Dose	Time(s) to be given	Side effects

Please list any special storage instructions: _____

If medication is an inhaler or EpiPen, may student self carry? YES ___ NO ___

As a licensed health care provider in the state of Ohio, and at the request of this student's parent/guardian, I direct that the above medication(s) be administered as indicated.

Prescriber's printed name and title: _____

Prescriber's signature: _____ Phone: _____ Date: _____

PARENT AUTHORIZATION AND EMERGENCY CONSENT

The information on this form is correct and complete to the best of my knowledge, and my child has my permission to participate in this event, with restrictions as noted. I understand and consent to the sharing of this information with all appropriate personnel who will be supervising my child for the duration of this trip or who may be responsible for the welfare of my child.

In the event I or another legal guardian cannot be reached in a medical or dental emergency, I consent for a school staff member to accompany my child to a medical facility. I authorize emergency medical or dental treatment by a licensed physician or dentist.

This authorization does not cover major surgeries or treatments unless the medical opinions of two other licensed physicians or dentists concur in the necessity and urgency for such surgery/treatments BEFORE they are performed.

NOTARY WITNESS TO PARENT/GUARDIAN SIGNATURE

Parent/guardian signature _____ Date _____

State of Ohio, County of _____

The foregoing instrument was acknowledged before me this _____ day of _____

by _____.

_____
Notary Public

My commission expires _____