

Plum Borough School District
Health Services Department

Student Health Information for an Extended Field Trip

Student's Name _____ Grade _____ Birth Date _____ Student's Weight _____
Last First

Address _____ Zip _____ Home Phone() _____

Date of Last Tetanus Shot _____ Wears Contacts _____ Glasses _____ Hearing Aid _____

List Allergies (to medications, food, environment, or insects):

Allergic to:	Type of Reaction (ex: local swelling, hives, etc.):	Treatment Required:
_____	_____	_____
_____	_____	_____

List Student's Current Medications (include dosage, frequency, and time given): _____

Current Health Problems: _____

List Previous Hospitalizations and Surgeries: _____

Does the Student Have a History of:	Yes	No	Explain Yes Answers Here:
Asthma, Pneumonia, Recurrent Cough, Respiratory Illness	_____	_____	_____
Attention Deficit Disorder, Mental or Nervous Disorder	_____	_____	_____
Bone or Muscle Disorders, Previous Orthopedic Injury	_____	_____	_____
Cancer, Blood Disorder, Inherited, Genetic Problems	_____	_____	_____
Diabetes, Other Endocrine Disorders	_____	_____	_____
Drug or Alcohol Problems	_____	_____	_____
Ear, Nose, Throat, Vision, Hearing Problems	_____	_____	_____
Gastrointestinal or Urinary Problems	_____	_____	_____
Head Injuries, Seizures, Dizziness, Concussion	_____	_____	_____
Heart Trouble, Murmur, Hole in Heart, High blood Pressure	_____	_____	_____
Migraines, Frequent Headaches	_____	_____	_____
Scoliosis (curvature of the spine)	_____	_____	_____
Skin Conditions-Hives, Rashes, Eczema	_____	_____	_____
Do you have any concerns about your child's emotional well-being or behavior?	_____	_____	_____
Any Other Conditions – (not listed above)	_____	_____	_____

Parent Name(s):	Place of Business:	Business Phone #:	Cellular #:	Beeper #:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other Emergency Contacts you authorize to make decisions regarding your child if unable to reach parent(s):

Name:	Relationship:	Home Phone#:	Business Phone#:	Cellular / Beeper #:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Physician's Name _____	Phone # _____
Dentist's Name _____	Phone # _____
Insurance Carrier _____	Name of Insured _____
Pre-Authorization Phone # _____	Group # _____ Agreement # _____

* I AGREE TO THE CONDITIONS AS STATED ON THE REVERSE SIDE OF THIS FORM. In addition, my child may receive the listed medications, and be provided the necessary care as described.
Other Instructions: _____

Parent/Guardian Signature _____ Date _____

Plum Borough School District
Health Services Department

Student Health Care Consent for an Extended Field Trip

Parents or Guardians must send their child's needed prescription medication in properly labeled pharmacy safety containers, and any required over the counter medications (not listed below) in the original manufacturer's packaging. Please use tape to label the over-the-counter medications with your child's name.

My signature, as the parent / legal guardian of the student named on the reverse side of this form, indicates that I give permission for all of the following:

1. I permit another adult or teacher that accompanies my child on the trip:

- To make any necessary decisions regarding care needed.
- To provide any needed first aid.
- To drive, or obtain transportation for my child (such as a cab), to a medical facility if his/her condition warrants.
- To call EMS personnel to transport my child to an emergency room, if necessary.
- To assist my child in taking any required medications.

2. I permit my child to be given any of the following over-the-counter medications (or their generic equivalents) according to package directions:

- | | |
|-------------------------------|---------------------------------|
| ▪ For pain or fever | Tylenol or Motrin |
| ▪ For upset stomach | Tums, Mylanta, Maalox |
| ▪ For cough | Robitussin DM or Cough Drops |
| ▪ For sore throat | Throat Lozenges |
| ▪ For severe nasal congestion | Sudafed |
| ▪ For small cuts | Topical Antibiotic Ointment |
| ▪ For itching | Calamine or Rhuli Anti-Itch Gel |
| ▪ For allergic reaction | Benadryl |
| ▪ For diarrhea | Imodium |

***Aspirin or medication containing Aspirin-Like compounds such as Pepto Bismol, Alka Seltzer Plus, or Kaopectate will not be administered to students due to the link between Aspirin and Reye's Syndrome.**

3. I give my permission for my child to be provided any care deemed necessary by a medical facility or emergency room.

4. I agree to pay for expenses not covered by my insurance, including any cost incurred by EMS or other transportation to a medical facility or emergency room.