Plum Borough School District
Nursing 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 <u>will not</u> 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.