GLEN ROCK MIDDLE-HIGH SCHOOL
Phone (201) 445-7700 HS X8958 MS X8931

FIELD TRIP MEDICAL/EMERGENCY CONTACT FORM

Student Name:_____ Grade:_____
Address:_____ Phone:_____

Parent/Guardian Contact Information

1. Name:_____ Relationship:_____
Phone: Home: _____ Work:_____ Cell: _____
2.Name:_____ Relationship:_____
Phone:Home:_____ Work:_____ Cell:_____

Emergency Contacts (to be contacted if parent/guardian unavailable)

1. Name:_____ Relationship:_____
Phone: Home: _____ Work:_____ Cell: _____
2.Name:_____ Relationship:_____
Phone:Home:_____ Work:_____ Cell:_____

Student's Physician Name:_____ Phone:_____
List any medical conditions, allergies, or special needs:

I give consent to the trip director and chaperones to obtain medical care for my child if necessary. Parents/guardians or the above listed emergency contacts will be notified as soon as possible. I hereby agree to release, indemnify and hold harmless the Board, its agents and employees, specifically including the chaperones from any liability as a result of an injury or damages arising from medical treatment provided to my child on the trip. **A COPY OF YOUR MEDICAL INSURANCE CARD MUST BE ATTACHED TO THIS FORM.**

PARENT SIGNATURE: _____ **DATE**: _____

STUDENT SIGNATURE:_____**DATE**:_____

Medication:
Unless students have been approved for self-administration of a particular medication pursuant to Board Policy 5330, students are not permitted to carry prescription or over the counter medications while on the field trip. If the need for medication is anticipated and you have not already complied with the procedures set form in Board Policy 5330 for the administration of medication, then the attached form must be completed and returned as soon as possible. For students who may need emergency administration of epinephrine, the procedures in Board Policy 5330 apply and must be completed prior to the field trip in order for your student to benefit from emergency epinephrine by a district employee on the field trip. The attached form is necessary in order for students to be administered all medications, including Tylenol, Advil and Motrin.
***All medications must be sent to school in the **ORIGINAL** container labeled by the Pharmacy or Physician.

GLEN ROCK MIDDLE/HIGH SCHOOL HEALTH OFFICE
PHONE: (201) 445-7700 x 8920 FAX: (201) 389-5048

FIELD TRIP MEDICATION AUTHORIZATION FOR ALL MEDICATIONS

Name _____Grade:_____Date of Birth:_____

I request that my child be administered the following medication. **(Includes Prescribed; Over-the-counter, Inhalers; Epipens)**

Parent/Guardian Signature:_____Date:_____

The following is to be completed by the **PHYSICIAN**.

Diagnosis:_____

Name of Medication:_____

Dose:_____

If medicine is to be given **DAILY**, at what time?_____

If medicine to be given "**WHEN NEEDED**", describe indications:_____

How soon can it be repeated?_____

List significant side effects:_____

Length of time this treatment is recommended_____

Physician's Signature:_____Date:_____

Physician's Stamp:

If a student is to self-administer (Inhaler/Epipen only) complete form on reverse side of this document.

**** ALL MEDICATIONS MUST BE SENT TO SCHOOL IN THE ORIGINAL CONTAINER LABELED BY THE PHARMACY OR PHYSICIAN.**
*****OVER THE COUNTER MEDICATIONS MUST FOLLOW THE SAME PROCEDURE**
******ONLY BRING ENOUGH MEDICATION FOR THE LENGTH OF THE TRIP (EXAMPLE: 3 DAYS/3 PILLS)``**

PARENT AUTHORIZATION FOR SELF-ADMINISTRATION OF INHALER/EPIPEN ONLY FOR THE _____ SCHOOL YEAR

Name of Student:_____

I request that my child be permitted to self-administer medication while attending a school function. I acknowledge that the Board, its agents and employees shall incur no liability as a result of any injury arising from self-administration of medication by my child. I hereby agree to indemnify and hold the Board, its agents and employees, harmless from any and all claims, liability, damages and expenses, including reasonable attorneys' fees arising out of, resulting from or in connection with the self-administration of medication by my child.

Signature(s) of Parent(s)/Guardian(s):_____

Date:_____ Phone:_____

Emergency Contact Name(s) and Telephone(s):_____

Medication and/or medical device to be used:_____

PHYSICIAN'S CERTIFICATION

Diagnosis:_____

Prescribed Medication:_____

Purpose of Medication:_____Dosage:_____

Time to be taken or special circumstances under which medication should be taken:
_____
How soon should it be repeated:_____
Duration of Prescription:_____
Possible side effects:_____
Comments:_____

The above student is a patient under my care. The student is being treated for a potentially life-threatening illness. The student has been instructed in, and is capable of, the proper method of self-administration of the above prescribed medication.

I certify that the above statements are true. I am aware that if any of the above statements are willfully false, I am subject to punishment.

Physician's Printed Name:_____
Physician's License Number:_____
Physician's Signature:_____
Date:_____