

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 Bethlehem Area School District staff, other than a nurse or physician employed by the District, cannot legally administer any medication to this student. I/We authorize this student to attend this Bethlehem Area School District approved trip. 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

SEE SECTION B REGARDING MEDICATIONS

SECTION B
to be completed by ALL students for overnight trips
(IN ADDITION TO THE MEDICAL INFORMATION FORM)

Student's name _____

The medications listed below will ONLY 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.

Medical Abbreviations: 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		

Students should provide an adequate supply of properly labeled medications as directed by their licensed prescriber and by their parent/guardian to the nurse assigned to the trip. Medication should be able to last the duration of the trip, plus an additional 3 days. A doctor's order is required for all medications being sent with the student on the trip. Medications will be maintained by the assigned nurse.

Pursuant to District policy 210 students may not carry medications other than selected medications as directed in writing by the prescriber, parent **and** CSN. Appropriate forms and consents must be completed, please list medications needed on trip: _____

If your student does not need any medications please state NONE above

I/We authorize the assigned nurse attending this trip to administer the above medications to the referenced student.

Parent/Legal Guardian Date

Parent/Legal Guardian Date