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 Nitschmann Middle School Grade _____ Date of Birth _____ Age _____

Trip Destination Pittsburgh, PA

Dates of Trip May 15 & 16, 2026

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

Students must complete page 2

SECTION*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
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		
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		
Antacid (Tums)	2 tabs P.O. at onset of indigestion sour stomach P.R.N. No more than 6 tablets in 24 hours.		
Throat Lozenge	1 lozenge P.O. q 2 - 3 hr., P.R.N. throat irritation		
Bacitracin Ointment	apply topically B.I.D. to minor wounds P.R.N.		
Anbesol	apply topically q 2 - 3 hrs. P.R.N. for tooth pain		

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

dt - Zsitek-Brannan-1/3/23