

BELLEVUE SCHOOL DISTRICT
Bellevue, Washington

EXTENDED FIELD TRIP and EMERGENCY HEALTH FORM

To be filled out by the parent/guardian of the student attending the camp or extended field trip and returned to his/her teacher no later than _____.

Name of student: _____ Birthdate: _____

Name of parent/guardian: _____

Home address: _____

Phone: Home: _____ Work (mother): _____ Work (father): _____

Cell/pager: _____ Cell/pager: _____

Student's physician: _____ Phone: _____

Name, address, and phone number of **two** people who could be contacted in case of emergency if the parent/guardian cannot be reached (relatives, close friends). These people may provide information regarding where the parent/guardian might be reached, or they might be asked to give advice/permission for medical care.

PLEASE NOTIFY THESE INDIVIDUALS THAT THEIR NAMES HAVE BEEN GIVEN FOR THIS PURPOSE.

1) Name: _____

2) Name: _____

Address: _____

Address: _____

Phone (day): _____

Phone (day): _____

Phone _____

Phone _____

(night): _____

(night): _____

Cell/pager: _____

Cell/pager: _____

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In the event that I/we cannot be contacted to authorize emergency medical treatment for _____ during his/her participation in the camp/field trip, the Bellevue School District staff member in charge of medical care has my permission to authorize emergency medical treatment. I also give permission for school staff to transport my child to a medical treatment center if needed.

Signature of parent/guardian _____

Date _____

Needed in case of emergency:

Name of insurance company: _____

Policy # _____

Name of Subscriber: _____

(OVER)

HEALTH INFORMATION: The following health conditions can be of concern; please check any that have been a problem in the past or are currently a concern.

CONDITION	PAST PROBLEM	CURRENT PROBLEM	PLEASE EXPLAIN
Abnormal bleeding	_____	_____	_____
Allergies (please circle: foods, environmental, medications, insects, other _____) If serious allergic reaction, e.g., bee sting, please complete the Allergy Information Form.	_____	_____	_____

CONDITION	PAST PROBLEM	CURRENT PROBLEM	PLEASE EXPLAIN
Diabetes	_____	_____	_____
Frequent infections (please circle: ear, throat, other _____)	_____	_____	_____
Heart/circulatory problems	_____	_____	_____
Hives	_____	_____	_____
Seizures	_____	_____	_____
Intestinal problems (including frequent stomach aches, constipation, diarrhea, indigestion, etc.)	_____	_____	_____
Respiratory problems (including asthma, bronchitis)	_____	_____	_____
Urinary problems (including bed wetting)	_____	_____	_____
Other, please indicate:	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is your child physically able to take part in all trip activities? Yes _____ No _____
If no, what limitations are needed?

DATE OF LAST TETANUS IMMUNIZATION _____

Medication(s) student is currently taking: _____

If medication(s) is to be taken during the trip, written instructions from the prescribing physician and parental permission **must** be obtained for **each** medication. A medication authorization form is attached and must be completed by a physician and returned/faxed to the school nurse. If more than one medication is to be taken, additional copies can be obtained at school. All medications will be kept and dispensed (as ordered by the physician) by a designated school employee. Prescription and non-prescription medication must be sent in the original pharmacy container. Non-prescription (over-the-counter medication) must be clearly labeled with the child's name, dosage and time to be given. **NO MEDICATION (prescription or non-prescription) CAN BE GIVEN WITHOUT A PHYSICIAN'S ORDER.** To accommodate medication needs, all physician medication orders and medication(s) must be to the school nurse by _____.