

EMERGENCY PROCEDURE/HEALTH INFORMATION for EXTENDED DAY, OVERNIGHT FIELD AND FOREIGN TRAVEL TRIPS

MUST BE COMPLETED BY PARENT FOR ANY STUDENT ATTENDING TRIP

STUDENT'S NAME				MALE	FEMALE
	LAST NAME	FIRST NAME	MIDDLE INITI	AL	
SCHOOL			GRADE	DATE OF B	IRTH
STREET ADDRESS					
CITY					
HOME PHONE	WORK	K PHONE		CELL PHONE	
FAMILY PHYSICIAN				PHONE	
PARENT/GUARDIAN	NAME				
		ification - Parent/G		FICATION ontacted first unless otherw O THE NEAREST HOSPIT.	
NAME OF PERSON		RELA	ΓΙΟΝSHIP	PHONE NUM	BER
NAME OF PERSON		HEAL	ΓΙΟΝSHIP TH INFORM list & give dates if	ATION	BER
Health conditions/op	erations:				
Handicapping Condi	tions:				
Allergies (medication	, food, insects, etc.)	:			
Describe the usual syn	nptoms/reactions:				
Medications (prescrip	tion and non-prescr	iption):			
	der (IFAS# 395130	35) is required.	Refer to attache	d Medication/Treatment	physician specific to Medication Order. MEDICATION MUS
Does your child have a	any activity restrictions?	ons? Yes Yes	No	If yes, please If so, what are restrict	explainions?
PARENT/GUARDIA	N SIGNATURE _			DA'	ГЕ
The information you staff as necessary to i			ential manner. I	nformation provided on	this form will be shared with
INSURANCE COMPA	ANY		POLICY (OR BINDER NUMBER	
PERMISSION IS GRA ANY MEDICAL OR S			OVE NAMED PAI	RTICIPANT BY A PHYSIC	IAN AND/OR HOSPITAL FOR
PARENT/GUARDIAN	SIGNATURE			DATE	

IFAS #39502293 **Packet** Revised 7/14/2014

Student Name: School: Reason for Medication:	dicati	on:	eaic:	ation	For	m/P	hysic		Gen	Gender:	Medication Form/Physician's Order (To be Completed by Physician/Authorized Health Care Provider) Gender: M F Date of Birth: Grade: Date of Order Expires End of School Year or (date): Order valid for current year including summer school (mple	Date Orde	Date of Birth: Grade: Date of Order: Order Expires End of School Year or (date): Order valid for current year including summer school (Check if appropriate)	irth: pires id fo	End r cur	of S	Grade: Chool Ye year incl	ed H de: lYez inclu	d Health Care Ie:I Year <u>or (date):</u> ncluding summ	(date sun	Te Fi	te of scho	Date of Order: : : : : : : : : : : : : : : : : : :	er: _ Chec	c if ap	propi	riate)[
Time to Give Medication:	Tedic:	ation					Z	Route:						Freque	Frequency of Medication:	y of	Medi	catic	Ď.		٦	Date	Suit. Date	Med	Bate Med. Expires:	ires					
Possible Side Effects:	ffects	s:											·	Alle	Allergies	'															
Special Instructions	ions												'																		
Student may carry and self administer medication for asthma or other airway constricting conditions	ıy car	ту аі	nd se	lf ad	minis	ster r	nedic	ation	1 for	asthr	na or	othe	r air	way o	const	rictir	ıg co	nditi	ons	MD	MD Initials	als								L	
PRINTED PHYSICIAN/PRÉSCRIBER NAME AND SIGNATURE	ED PI	SAH	[CIA	N/PI	ESC	RIB	ERI	AM	EAN	D SI	GNA'	IUR	(Ŧ)						F	PARENT/GUARDIAN SIGNATURE	NT/	GUA	RDI	ANS	IGN	ATU	RE				
							Med	icati	ion /	∆dm	Medication Administration Record (For School Use Only)	ratio	on R	eco	д (F	or S	cho	<u>ol</u> U	se (Only	<u> </u>										
Nurse Reviewed:	ed:							Da	tes R	Dates Reviewed:	wed:																				
	1 2	3	4	. 5	6	7	~	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
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								1 1 1													5 5 5	A: Absent N: None Available NS: No Show to H	one /	\vail	A: Absent N: None Available NS: No Show to HR		7: Re	R: Refused O: Omitted H: Dose Held	id id Held		
Nursing assessement has been completed for student self-administration Student may / may not self administer (Circle One)	nent h	has be	en co	ompl niste	eted f	or stu	d for student (Circle One)	self-a	admir	nistra	ion	Z	RN Signature	natur	œ			Date				/E.C.	Med	l Dis	D/C: Med. Discontinued L/E Late Arrival/Early F	inue arlv]	d Dism	D/C: Med. Discontinued L/E Late Arrival/Farly Dismissal	_		
HCBcc/DcECc/Occ/Health Carrigosc/Madi	1		Madia		2	<i>'</i>) TO (TO ()						(i	į					