

Student Name \_\_\_\_\_

(Last, First)

**PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT**

**Plainview-Old Bethpage Middle School**

**Medical Emergency Information Field Trip Form**

**A. To be completed by the Parent or Guardian:**

I request that my child \_\_\_\_\_ (Date of birth: \_\_\_\_\_) receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy\*. I understand that the school nurse or her designee in the event of her absence will assist the child.

Signature (Parent or Guardian): \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Date \_\_\_\_\_

**B. To be completed by the Private Healthcare Provider:**

I request that my patient, as listed below, receive the following medication:

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis: \_\_\_\_\_

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any):

Prescriber's Signature & Stamp \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\* Medication must be in original pharmacy labeled container with specific orders and name of medication.

\* Medication and refills must be brought to school by parent, guardian or responsible adult.

**C. Supplemental Information:**

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Student's Medical Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Please list all allergies and indicate if medication is necessary:

\_\_\_\_\_

Please list any health or dietary conditions requiring special consideration (ie: asthma, diabetes, gluten free).

\_\_\_\_\_

*This form must be completed and returned by Friday, January 27, 2017. Please provide updated information if anything changes prior to the field trip on April 26, 2017.*