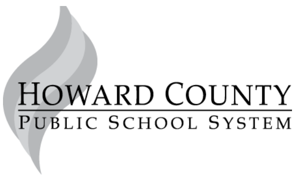

EMERGENCY PROCEDURE/HEALTH INFORMATION for EXTENDED DAY, OVERNIGHT FIELD AND FOREIGN TRAVEL TRIPS

MUST BE COMPLETED BY PARENT FOR ANY STUDENT ATTENDING TRIP

STUDENT'S NAME ______________________________ MALE_____ FEMALE_____
LAST NAME FIRST NAME MIDDLE INITIAL

SCHOOL ______________________ GRADE ________ DATE OF BIRTH ____________

STREET ADDRESS ____

CITY ______________________________ ZIP CODE ________________

HOME PHONE __________ WORK PHONE ______________ CELL PHONE ______________

FAMILY PHYSICIAN ______________________________ PHONE ______________

PARENT/GUARDIAN NAME ____

EMERGENCY NOTIFICATION

(List in order of Notification - Parent/Guardian will be contacted first unless otherwise specified.)
MAJOR EMERGENCIES WILL BE TAKEN TO THE NEAREST HOSPITAL

____
NAME OF PERSON RELATIONSHIP PHONE NUMBER

____
NAME OF PERSON RELATIONSHIP PHONE NUMBER

HEALTH INFORMATION

(Please list & give dates if known)

Health conditions/operations:

Handicapping Conditions:

Allergies (medication, food, insects, etc.):

Describe the usual **symptoms/reactions**:

Medications (prescription and non-prescription):

If prescription or over-the-counter medication is to be taken, a separate written order from your physician specific to Medication Form/Physician's Order (IFAS# 39513035) is required. Refer to attached Medication/Treatment Order. MEDICATION MUST BE PROVIDED FROM HOME. There will not be a school nurse in attendance on this trip.

Does your child have any activity restrictions? Yes_____ No _____ If yes, please explain.______________________
Does your child have dietary restrictions? Yes_____ No _____ If so, what are restrictions?_________________________

PARENT/GUARDIAN SIGNATURE ______________________________ DATE ______________

The information you provide will be handled in a confidential manner. Information provided on this form will be shared with staff as necessary to maintain your child's safety.

INSURANCE COMPANY __________________________________ POLICY OR BINDER NUMBER ____________________________

PERMISSION IS GRANTED FOR TREATMENT OF THE ABOVE NAMED PARTICIPANT BY A PHYSICIAN AND/OR HOSPITAL FOR ANY MEDICAL OR SURGICAL EMERGENCY.

PARENT/GUARDIAN SIGNATURE _______________________________________ DATE___________________________

MEDICATION PROCEDURE INFORMATION

School system requirement for medication administration must be followed in order for students to take medication during school hours and school sponsored events.

1. Parents must provide a written authorization for **any** medicine to be administered. This includes over-the-counter medicine (including medicated cough drops), homeopathic medicine, and prescription medicine.
2. **The first dose of any new prescription must be given at home.**
3. The parent/guardian is responsible for obtaining a written the medication order. The attached medication form/physician's order is preferred. An authorized prescriber (physician, dentist, physician's assistant, nurse practitioner) may use office stationary or a prescription pad instead of completing the attached form. The authorized health care provider must sign the order form. Necessary information includes:
   - Name of student
   - Date of medication order
   - Name of medication
   - Dosage and strength of medication
   - Route of administration
   - Date order expires (Check box if order valid for summer school.)
   - Time and frequency of medication
   - Diagnosis (Reason for administration of medication.)
   - Authorized health care provider signature
   - Special instructions (including whether or not medication may be self-administered or carried by the student

   Note: PRN medications should have the **frequency** of repeat doses clearly indicated on the order.
4. Occasionally students may need to self-administer/carry medication such as inhalers or emergency medication. A written medication order, signed by an authorized health care provider, that specifically states that the student may self-administer/carry medication, must be on file in the health room for any student who carries medication throughout the school day.
5. **A new medication order is required for each new school year dated on or after July 1.**
6. The medication should be delivered to the school by the parent/guardian or, under special circumstances, an adult designated by the parent. Students should not transport medication to or from school.
7. All medication must be properly labeled and consistent with the medication order. Pharmacy containers and labeling are preferred; ***a second labeled container can be obtained by asking the pharmacist.*** Parents should label over-the-counter medication. Physician samples must be appropriately labeled by the physician or parent/guardian. The following information must be on the label:
   - Name of the student
   - Date of the medication order
   - Name of the Medication
   - Route, time, and frequency of the medication
   - Dosage and strength of the medication
   - Authorized health care provider name
8. Over the counter medications must be received in new, unopened containers and be clearly labeled with the student's name.
9. The school nurse must approve the medication order before the first does of medication can be administered at school.
10. The parent/guardian is responsible for submitting a new medication order form to the school each time there is a change of dose or time of administration or route of administration.
11. The parent must provide medication for as long as it is prescribed. All medication kept in the school will be stored in a locked area accessible only to authorized personnel.
12. Within one week after expiration of the effective date on physician's order, the parent/guardian must personally collect any unused portion of the medication. Medication not claimed within that period will be destroyed.
13. Expired medication cannot be given. The effective expiration date of a medication is the earlier of either the pharmacy labeled expiration date or the manufacturers expiration date.
14. Each student's confidentiality will be maintained to the extent possible by school staff. At times, school personnel outside of the health services program may need to be made aware by health services staff that a student is receiving medication in order to monitor effectiveness, side effects, adverse reactions, or in response to other legitimate school related issues or responsibilities. Information will be shared on a need-to-know basis only.
15. Under no circumstances may any school staff administer **any** medication outside the procedures outlined in the Health Services Medication Administration Procedure.
16. The Howard County Public School System does not assume responsibility for medication administered outside of the Health Services Medication Administration Procedure.

HCPSS SCHOOL HEALTH SERVICES

Medication Form/Physician's Order (To Be Completed by Physician/Authorized Health Care Provider)

Student Name: ____________________ Gender: M F Date of Birth: ________ Grade: ________ Date of Order: ________

School: ____________________ Order Expires End of School Year **or** (date): ________

Reason for Medication: ____________________ Order valid for current year including summer school (Check if appropriate) ☐

Name of Medication: ____________________ Dose: ________ Strength: ________

Time to Give Medication: ________ Route: ________ Frequency of Medication: ________ Date Med. Expires: ________

Possible Side Effects: ____________________ Allergies: ____________________

Special Instructions ____________________

☐ Student may carry and self administer medication for asthma or other airway constricting conditions MD Initials ☐

PRINTED PHYSICIAN/PRESCRIBER NAME AND SIGNATURE

PARENT/GUARDIAN SIGNATURE

Medication Administration Record (For School Use Only)

Nurse Reviewed: **Dates Reviewed:**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															
July																															

Name/Position	Initials	Name/Position	Initials

CODES: Chart reason (See H.S. Manual)

X: School Closed FT: Field trip
A: Absent R: Refused
N: None Available O: Omitted
NS: No Show to HR H: Dose Held
D/C: Med. Discontinued
L/E Late Arrival/Early Dismissal

Nursing assessement has been completed for student self-administration ____________________

Student may / may not self administer (Circle One) RN Signature Date

HCPSS/DSFCS/OSS/Health Services/Medication Order Form /pat/7/05