STUDENT MEDICAL INFORMATION/HISTORY
This side to be completed by Parent or Legal Guardian

Personal Information

Student's name		Age	
		Grade	
Parent/Guardian Name(s)			
Home Phone			
Cell Phone			
Work Phone			
Home Address (incl. Zip Code)			

Emergency Contacts

Family Physician		Phone	- -
Emergency contacts		Phone	- -
Relationship		Cell	- -

Medical Insurance

Does student have insurance through parent employer or personal insurance?			Yes / No
Medical Insurance Carrier		Policy Number	

Health History and Allergies

Health History: (check) *Explain, as needed, on reverse side*		Allergies: (list)	
☐	Diabetes	Medications:	Foods:
☐	Orthopedic Problems		
☐	Asthma		
☐	Epilepsy	Latex:	Insects:
☐	Cardiac Problems		
☐	Anaphylaxis		

Has your child had a tetanus shot in the past 10 years?	Yes / No Date: ___/___/_____

Does your child have any special needs or medical considerations we need to be aware of? If yes, please explain.	Does your child require special accommodations (IEP/504 plan)? If yes, please explain.	Does your child take daily prescribed medications? If yes, please list.

CONFIDENTIALITY STATEMENT AND LEGAL NOTICE
This side to be completed by Parent or Legal Guardian

Confidentiality Statement: By law, all knowledge of student medical information and health forms are kept confidential by medical personnel and BCPS employees.

Prescribed and OTC Medications: **All** prescribed and over-the-counter medication is to be turned into the attending Registered Nurse on the day of departure to Walt Disney World in Orlando, FL. **All** medication while on the trip is to be kept in the possession of and administered by the attending Registered Nurse.

Parent's Authorization: This health history is correct and complete to the best of my knowledge and the student herein described has my permission to engage in all activities, unless otherwise noted by myself. I give permission to the physician or hospital selected by the nurses on staff to hospitalize, secure proper treatment for, and to order medications, injecting anesthetics or surgery for my child as named above. I acknowledge that any financial obligations as a result of the above actions are my responsibility. I also hereby give my permission for the nurse in attendance to administer medication during the field trip to my child as delegated by the staff noted above.

Student name: _____

Parent name (print): _____

Parent signature: _____ Date: _____

Health history explanation (as needed):

_____

_____

_____

_____

HEALTH CARE PROVIDER'S ORDER FOR MEDICATION
This side to be completed by Health Care Provider

Dear Health Care Provider:

Please indicate below any prescription and/or over-the-counter medications that your patient is currently taking and will need to continue to take while on this trip. Please fill out the form to the best of your ability/knowledge. If our nurses have any questions for you, they will be in contact with you prior to the trip.

_____ _____
Student's name (print) Date of Birth

To be completed by the Physician:

Medications/Treatments	Dosage/Frequency of Administration	Circumstances/symptoms for administrations	Diagnosis

The above chart MUST include any over-the-counter medication including medicines like Acetaminophen (Tylenol), Ibuprofen (Advil), Antacids (Tums), Diphenhydramine (Benadryl), Cough Drops, Throat Lozenges, Dramamine, etc. Without written approval from a doctor, the attending nurse(s) may NOT dispense any medication.

Signed by prescribing health care provider: _____

Date: _____