Bellevue Public Schools
Bellevue, Washington

EXTENDED FIELD TRIP EMERGENCY HEALTH FORM

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

Name of student: _____ Birthdate: _____

Social Security Number: _____ (Disclosure of SS# is voluntary. It will be used for securing emergency medical care).

Name of parent/guardian: _____

Home address: _____

_____

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

Cell/pager _____ Cell/pager _____

Email address: _____

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 (night): _____	Phone (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: _____

Name of Subscriber: _____

Policy # _____

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. If your student has a **life threatening condition** (severe asthma, severe allergic reaction, diabetes, seizures, etc.), a Health Care Plan **must** be attached.

CONDITION	PAST PROBLEM	CURRENT PROBLEM	PLEASE EXPLAIN
Abnormal Bleeding			
Allergies			
Please circle type of allergy: foods, insects, medication, environmental, other**			
Diabetes**			
Frequent infections			
Heart/circulatory problems			
Seizures**			
Intestinal problems (including frequent stomach aches, constipation, diarrhea, indigestion, etc.)			
Respiratory problems (including asthma, bronchitis)**			
Urinary problems (including bed wetting)			
Other, please indicate			

**Attach Emergency Health Care Plan

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. <u>If more than one medication is to be taken, additional copies can be obtained at school</u>. 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. <u>NO MEDICATION (prescription or non-prescription) CAN BE GIVEN WITHOUT A PHYSICIAN'S ORDER</u>. To accommodate medication needs, all physician medication orders and medication(s) must be to the school nurse by _____.**