TENAFLY PUBLIC SCHOOLS

Field Trip Medical Form

Please read, consider and answer the following statements carefully before signing.

Student's Name

Last ____________________ First _______________ Initial_____

I. Health Information. My child has the following:

A. dietary needs:

B. allergies:

C. specific medical conditions:

D. other conditions of which the school should be aware:

E. Date of most recent tetanus booster:

II. Medications. Only medications prescribed by a licensed physician may be administered to a child and only by a registered nurse or physician. If your child requires medication (prescription or non-prescription) please complete the attached Medicine Dispensing Form (Exhibit II).

NOTE: If a child is to receive a prescription medication during the course of a field trip, a school nurse, other individual licensed to administer medication or parent must accompany the student to administer the medication unless the pupil has been authorized by a physician to self administer the medication. .

III. Medical Emergency. In the event of a medical emergency, the procedure on this trip will be to call the parent, time permitting, before taking a student to a doctor or hospital. When a parent/guardian, or his/her designee, cannot be reached, the following permission will permit prompt attention. In the event of an emergency, I acknowledge that school personnel shall attend to the immediate safety of my child prior to notification of the parent/guardian.

I give permission for the school field trip leader or designee to sign any consents, which may be necessary to allow hospital personnel and/or licensed personnel to examine my child and perform any emergency procedures, or emergency treatment which may be necessary. In providing this consent, I acknowledge that the Tenafly Public Schools are not in any way responsible and shall incur no liability for the actions of hospital, emergency ambulance and/or medical personnel, and as such I indemnify, hold harmless and waive any right of legal action against the Tenafly Public Schools for the actions of said personnel."

Emergency Information

Student Name____

Parent/Guardian(s) Name(s) ______________________________________

Home Address:____

Daytime Phone No(s).____________________Evening Phone No. ____________

____________________Cell Phone No.________________________________

If parent/guardian cannot be reached in an emergency, call____________________at

Telephone No(s):________________________________

Employees and agents of the District will be held harmless as well as the District.

Student's Physician______________________ Office Phone No. ____________

I understand and agree to all of the above terms

________________________________ ______________________

Parent/Guardian Signature Date

____

Parent/Guardian Name (print)

TENAFLY PUBLIC SCHOOLS
TENAFLY, NEW JERSEY

EXHIBIT II (51606153)

MEDICATION DISPENSING FORM - PARENT/GUARDIAN

NOTE: I give the School Nurse permission to contact the physician and/or pharmacist with any question concerning the medication.

Student's Age ___________ Grade__________ School_________________

Name and Strength of Medication____

Time of Administration__________ Dosage__________

Prescription ( ) Non-Prescription ( ) Effective Dates: from__________ to_

Reason for Medication (Diagnosis) ____

Parent/Guardian's Name ____
Parent/Guardian's Signature

Date: Telephone No.:

TENAFLY PUBLIC SCHOOLS
TENAFLY, NEW JERSEY

MEDICATION - PHYSICIAN FORM

Child's name:______________________________________

MEDICATION: Name_______________________________ Strength_________________________

Dosage__________________ Time of Administration_____________________________________

Effective Date from__________________to_____________

Purpose of Medication:

Physician's Name (please print)____

Physician's Signature____

Date____________ Telephone No.____

TENAFLY PUBLIC SCHOOLS
TENAFLY, NEW JERSEY

PHYSICIAN'S FORM FOR EMERGENCY/SELF-ADMINISTERED MEDICATION

It is essential that (student's name) ________________________________ be permitted to carry and administer the following medication for the purpose of treating (diagnosis)__________ ____________, which is either asthma or a potentially life threatening illness or allergic reaction. This can be done under the supervision of the School Nurse, in case of an emergency, or if the School Nurse is not available.

I have instructed this child in the procedure for administration of the medication and find him/her competent to administer this medication.

MedicationName____

Dosage____________________Time of Administration__________________

Effective Date from   to______________________

Physician's Name (please print)________________________________

Physician's Signature ____

Date___________   Telephone No.________________________

Parent approval for student self-medication: It is understood that the Tenafly School District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil, and shall indemnify and hold harmless the district and its employees/agents against any claims arising out of the self-administration of medication by the pupil. Employees and agents of the District will be held harmless as well as the District.

I understand that only enough medication for the school day or enough for a field trip is to be carried by the student, which is to be pre-measured and in the original prescription container. The privilege of self-administration of medication may be revoked if the pupil fails to comply with school policy or endangers himself/herself of others.

Parent Signature________________________ Date________________

(To be completed annually)

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