MEDICAL EMERGENCY FORM

New Providence High School
New Providence, NJ 07974

Instructions: This form will provide important information to medical personnel to whom your child is taken in the event of a medical emergency, while on this school-endorsed trip. Please complete <u>ALL</u> sections as accurately and as clearly as possible. WRITE "N/A", IF INFORMATION DOES NOT APPLY TO YOUR CHILD. ***Care will be taken to see that the following information will be held in confidence.***

Student's Name: _____

Home Address: _____

Home Phone: _____ Birth Date: _____

Insurance Company: _____ Policy ID#: _____

<u>EMERGENCY CONTACTS:</u>

Parent/Guardian: _____ Work/Cell #s: _____

Parent/Guardian: _____ Work/Cell #s: _____

Other Contact: _____ Phone #: _____

Family Doctor: _____ Phone #: _____

<u>MEDICAL INFORMATION:</u>

1. Allergies (food, drug, other): _____
2. Chronic medical condition(s): _____
3. Date of last tetanus shot: _____
4. Other items of concern: _____

******Will student require any of the following during the trip? (<u>CIRCLE</u> all that apply) IF YES, a Medication Administration Form <u>must be completed by your physician</u> and returned by the due date.******

MEDICATION ASTHMA INHALER EPI-PEN

<u>Parental Authorization</u>

In case of medical emergency, in the event I cannot be reached, I authorize New Providence High School, its agents, employees and other officers to procure and consent to any medical examination, diagnostic process or course of treatment, including hospital care, to be rendered to my child by or under the supervision of any duly licensed doctor, dentist, surgeon, or other health care professional.

_____ _____

Parent/Guardian Signature Date

DUE DATE:

MEDICATION ADMINISTRATION AUTHORIZATION FORM

New Providence High School
New Providence, NJ 07974

In accordance with the New Jersey Department of Education Guidelines for School Health and New Providence Board of Education Policy: "No prescription or over the counter medication will be administered without a written order from the student's physician or licensed prescriber and without a written request by parent or guardian for administration". All medications must be sent in the original containers. For the duration of the trip, all medications will remain in the possession of the registered nurse in charge, who will administer the medication to your child in a confidential manner. **STUDENTS WHO SELF-ADMINISTER THEIR INHALERS OR EPIPENS MUST ALSO HAVE THE REVERSE FORM COMPLETED**.

Student Name: _____ DOB: _____

Parent/Guardian: _____ Home #: _____

Work/Cell #: _____

I request that my child be allowed to take the medication(s) described below during the school-sponsored trip, to be administered by the trip nurse. I shall indemnify and hold harmless the district and its employees or agents for any legal fees, costs and any potential damages concerning administration of this medication arising out of any claims brought by the above-named child or anyone else.

_____ _____

Parent/Guardian Signature Date

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:

Medication	Dose	Frequency	Route	Time

_____ _____

Physician's Signature Date

_____ _____

Physician's Name (Stamp or Print) Phone Number

DUE DATE:

AUTHORIZATION FOR SELF-ADMINISTERED ASTHMA/EMERGENCY MEDICATION

New Providence High School
New Providence, NJ 07974

New Jersey State Assembly Act A-2600 directs that students may be permitted to self-administer medication for asthma and other potentially life-threatening illnesses, provided the proper procedures are followed. The law also states that parents must give written permission for their child to do so. Otherwise, the medication must be kept with school personnel.

Student Name: _____ DOB: _____

Parent/Guardian: _____ Home #: _____

Work/Cell #: _____

I request that my child be permitted to carry and self-administer his/her Epipen or inhaler during the school-sponsored trip, as authorized by my physician below. I accept full responsibility for making sure that my child carries the drug at all times. I release the district and its employees from any liability as a result of any injury arising from the self-administration of this medication.

_____ _____
Parent/Guardian Signature Date

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:

I have instructed the above-named student in the use of his/her Epipen or inhaler, and he/she may be permitted to carry the medication on his/her person and self-administer it as instructed by me.

Diagnosis for which medication is given: _____
Name of medication: _____
Dose: _____
Method of administration: _____
Possible side effects and/or precautions: _____
Known allergies: _____
Emergency Intervention Protocol: _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Name (Stamp or Print) Phone Number

DUE DATE: _____