Middletown High School South

900 Nut Swamp Road
Middletown, New Jersey 07748

Spring Music Department Trip
Medical Information &
Authorization for Emergency Health Treatment

NAME_____ **DATE OF BIRTH**_____

Students will be responsible for taking their own medication. All prescription medication must be in the original container with the student's name, dosage, and frequency of the medication clearly labeled. In addition, a written order or note from the prescribing physician and a note from the parent or guardian must be submitted with the medication. Over-the-counter medication must be in a new, sealed container and accompanied by parental permission. Supplements and capsules, which appear to be medication, if not prescribed, will be considered a substance under the District's Substance Abuse Policy #5530.

Student's Physician: _____ Phone #: _____

Address: _____

Is your son/daughter currently under a physician's care?

YES _____ NO _____

If YES please state reason: _____

Is your son/daughter currently taking any prescription drugs?

YES _____ NO _____

All prescription drugs must be accompanied by a written note from the physician. Please list all medications. A separate list may be attached if necessary. _____
_____
_____

Do you give your son/daughter permission to take over-the-counter, non-prescription medication (For example: Tylenol, Benadryl, Imodium, etc.) that is already in their possession? If yes please list the medication(s) your child will be carrying.

Please **initial**: YES _____ NO _____

_____

Do you give the school staff or chaperones permission to give your son/daughter over-the-counter, non-prescription medication if necessary? If yes please list any over the counter medications that your child **cannot** receive for any reason.

Please **initial**: YES _____ NO _____

_____

Does your son/daughter suffer from any health problems? **(This will remain confidential, but, shared with staff on a need to know basis).**

YES _____ NO _____

Explain in as much detail as necessary:_____

_____

_____

Does your son/daughter suffer from asthma? YES _____ NO _____

Do they require a rescue inhaler? YES _____ NO _____

Does your son/daughter have any allergies, including allergies to medication?

YES _____ NO _____

Explain in as much detail as necessary:_____

_____

_____

Does your son/daughter have a history of Anaphylaxis? YES _____ NO _____

Do they carry an Epi-Pen? YES _____ NO _____

PLEASE ATTACH A COPY OF THE CHILD'S INSURANCE CARD TO THIS FORM

Medical Insurance for Above Named Minor ☐ **None**

Primary Insurance Holders Name:_____ Primary Insurance Holders Social Security #_____

Primary Insurance Holders Date of Birth:_____ Home Address:_____

Place of Employment:_____ Occupation:_____

Employment Address:_____ Work Phone #:_____

_____ ___ _____

Name of Health Insurance Co. (i.e. Blue Cross/Blue Shield, etc.) I.D. or Contract Number

The above named students, and I, being the parent or guardian of the above named student, do hereby appoint Mr. Raguseo and Mrs. Kaster as representatives of Middletown High School South to act in our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named student during the Spring Music Department Trip – April 19th to 21st, 2013. **Medical information, although confidential, may be shared with staff, doctors, EMS, other medical personnel, or the hospital if the need arises.**

I have received and accept the terms, conditions and rules and regulations of the Spring Music Department Trip.

_____ _____

Parent/Guardian Home Phone # Parent/Guardian Cell Phone #

_____ _____

Student's Signature Parent/Guardian Signature