Bellevue School District
Procedure 2320P Exhibit E

OUT OF STATE OR OVERNIGHT FIELD TRIP EMERGENCY HEALTH FORM

To be filled out by the parent/guardian of the student attending the out-of-state or overnight field trip or camp and returned to the BSD employee responsible for the trip no later than: _____.

Name of student: _____ Birthdate: _____

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

Name of parent/guardian: _____

Home address: _____

Phone: Home: _____

Work # (Parent 1) _____ Cell #:_____ Email address: _____

Work # (Parent 2) _____ Cell #:_____ 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: _____	Cell: _____

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

Date: 8:14