TENAFLY PUBLIC SCHOOLS

FIELD TRIP AND EMERGENCY CONTACT FORM 2016-2017

Student's Name: _____

Last **First** **Initial/Nickname**

Student's Grade (Sept. 2016) _____ **Team (if known)** _____

I. EMERGENCY AND HEALTH INSURANCE INFORMATION

Home Address:	_____	Telephone #	_____
Father's Name	_____	Cell Phone #	_____
Father's Work Place	_____	Telephone #	_____
Mother's Name	_____	Cell Phone #	_____
Mother's Work Place	_____	Telephone #	_____
Two (2) Emergency contacts if parents are unavailable:			
Name:	_____	Telephone #	_____
	_____	Cell Phone #	_____
Name:	_____	Telephone #	_____
	_____	Cell Phone #	_____
Physician:	_____	Telephone #	_____
Dentist:	_____	Telephone #	_____
	_____		_____
Health Insurance Status:	Is student currently insured: Yes ( ) No ( )		_____
Name of Health Insurance Provider:			_____

II. MEDICAL EMERGENCIES:

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.

III. UPDATED HEALTH HISTORYAND INFORMATION

My child has the following (*Please read, consider and answer the following statements carefully before signing):*

A. Dietary needs: _____

B. Allergies: _____

C. Specific medical conditions and/or illnesses:_____

_____

D. Other conditions of which the school should be aware (surgeries, serious injuries, etc.):_____

_____

E. Date of most recent tetanus booster: _____

F. I give my permission for my child's health information to be shared with pertinent school staff if necessary to maintain his/her wellbeing and safety. Yes ( ) No ( )

The signature below attests to the fact that the above information will be in force for the 2016-2017 academic year.

_____ _____

Parent/Guardian Signature (*MANDATORY*) **Date**

THIS SIDE TO BE FILLED OUT FOR STUDENTS WHO TAKE MEDICATION

Student's Name (Last, First): _____ **Grade/Team:** _____

IV. 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 Medicine Dispensing form.

NOTE: If a child is to receive a prescription medication during the course of a field trip, a school nurse or School Health Aide must accompany the students to administer the medication, or the parent may accompany the child on the field trip to administer the medication, or the self-administration section is completed below.

V. PHYSICIAN'S REQUEST/INSTRUCTIONS FOR MEDICINE TO BE GIVEN BY SCHOOL NURSE

TO BE FILLED OUT BY PHYSICIAN (IF APPLICABLE)

The following medication is to be administered to my patient (state patient's name): _____

MEDICATION _____ DOSE AND ROUTE _____

TIME GIVEN _____ DIAGNOSIS _____

SIGNIFICANT SIDE EFFECTS _____

LENGTH OF TREATMENT _____ _____ _____

M.D. Signature M.D. Name (Please Print)

VI. PHYSICIAN'S REQUEST / INSTRUCTIONS FOR STUDENT SELF-ADMINISTRATION OF MEDICATION FOR A POTENTIALLY LIFE THREATENING ILLNESS. TO BE FILLED OUT BY PHYSICIAN (IF APPLICABLE)

The following medication is to be self-administered by my patient, _____.
I hereby certify that my patient has a life threatening illness and that my patient is capable of and has been instructed in the proper administration of the required medication.

MEDICATION _____ DOSE AND ROUTE _____ TIME GIVEN _____

DIAGNOSIS _____ LENGTH OF TREATMENT _____

SIGNIFICANT SIDE EFFECTS _____

_____ _____ _____ _____

M.D. Signature M.D. Name (Please Print) Date Physician's Phone Number

---

VII. PARENT REQUEST AND RELEASE TO BE COMPLETED BY PARENT/GUARDIAN

I request my child, _____ to (receive) (self-administer) the medication designated above. I have been informed by the school district that the school district, its agents, servants, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medicine by my child. I hereby indemnify and hold harmless the **TENAFLY BOARD OF EDUCATION,** its agents, servants, and employees from any and all claims and shall defend any lawsuit that may arise out of or in connection with the administration of medicine by my child.

_____ _____

Date Signature of Parent/Guardian