#1

MIDLAND PARK MIDDLE-HIGH SCHOOL
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DISTRICT FIELD TRIP MEDICAL/EMERGENCY CONTACT FORM

Student Name: _____ Grade: _____

Address: _____ Home phone: _____

Parent/Guardian Contact Information

1. Name: _____ Relationship: _____
   Phone: Home _____ Work _____ Cell _____

2. Name: _____ Relationship: _____
   Phone: Home _____ Work _____ Cell _____

Emergency Contacts (to be contacted if parent/guardian unavailable)

1. Name: _____ Relationship: _____
   Phone: Home _____ Work _____ Cell _____

2. Name: _____ Relationship: _____
   Phone: Home _____ Work _____ Cell _____

Student's Physician Name: _____ **Phone:** _____

List any medical conditions, allergies, or special needs:

I give consent to the trip director and chaperones to obtain medical care for my child if necessary. Parents/guardians or the above listed emergency contacts will be notifred as soon as possible. I hereby agree to release, indemnify and hold harmless the Board, its agents and employees, specifically including the chaperones from any liability as a result of an injury or damages arising from medical treatment provided to my child on the trip. **A COPY OF YOUR MEDICAL INSURANCE CARD MUST BE ATTACHED TO THIS FORM FOR OVERNIGHT TRIPS.**

PARENT SIGNATURE _____ **DATE** _____

STUDENT SIGNATURE _____ **DATE** _____

Medication:
Unless students have been approved for self-administration of a particular medication pursuant to Board Policy, students are not permitted to carry prescription or over the counter medications while on the field trip. If the need for medication is anticipated and you have not already complied with the procedures set forth in Board Policy for the administration of medication, then the attached form must be completed and returned as soon as possible. For students who many need emergency administration of epinephrine, the procedures in the regulations apply and must be completed prior to the field trip. The attached form is necessary in order for students to be administered all medications, including Tylenol, Advil and Motrin.

***All medications must be sent to school in the ORIGINAL container labeled by the Pharmacy or Physician.

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MIDLAND PARK PUBLIC SCHOOLS
MIDLAND PARK, NEW JERSEY
MEDICATION PERMISSION FORM

I hereby request the following medication to be given to my child at the prescribed time and dosage by a Registered Nurse.

Name:_____School:_____

Address:_____Age:_____Grade:_____

_____

_____ _____
Date Parent/Guardian Signature

TO BE FILLED IN BY PRIVATE PHYSICIAN

Diagnosis _____

Name of Medication _____

Dosage_____

Time frame of Administration _____ _____
(Earliest Time) (Latest Time)

Duration of Administration _____

Side Effects _____
Any restrictions the medication might make on the student's daily activities? _____

For PRN medications: conditions under which the drug is to be used

_____

Other medications the pupil receives that might enhance, alter or impact the effects of the ordered medication: _____

_____

_____ _____
Date Physician's Signature and stamp

_____ _____
Date School Physician's Signature

Please Note:
1. Medication is to be brought to school by the parent/guardian in the original container, labeled by the pharmacy.
2. All medications will be kept in a locked storage area.

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