PARKWAY SCHOOL DISTRICT HEALTH SERVICES
HEALTH INFORMATION
OVERNIGHT/OUT OF TOWN FIELD TRIP
ELEMENTARY/MIDDLE SCHOOL

Dear Parent/Guardian:

Please complete this health information sheet and return to teacher as soon as possible, before ___________

Student's name: ________________________________ Date of Birth: __________________ M: ☐ F: ☐

Address: ______________________________________ City/ State/ Zip code: ________________________

Parent/Guardian ____________________ Work Phone: _________ Home Phone: __________ Cell: __________

Emergency Contact: ___________________________________ Phone: _____________________________

Student's Physician: ___________________________________ Phone: _____________________________

Will your child bring medication (prescription or over-the-counter)? YES ☐ NO ☐

If yes, please specify: (Parent Signature below authorizes medication to be given by staff)

Name of medication	Physician	Dosage/Frequency	Times/Special Instructions	Teacher to complete: Date/ Time/ Initials

All medication will be administered by Parkway staff, and must meet the following criteria:

Prescription Medication:
A prescription medication must be in the **original prescription bottle** with a current prescription label properly affixed to the medication in question. The label must contain the name of the student, name of drug, dosage, frequency of administration, route of administration, diagnosis and physician's name.

Over-the-counter Medication:
This medication must be in the **original bottle accompanied by a Physician's order/authorization**. Write child's name on the bottle. Per school district protocol, homeopathic and naturopathic medications, vitamins and supplements will not be administered.

Please provide other health information that would help us meet the needs of your child. Include such conditions as: serious allergies, asthma, diabetes, ear and eye problems, heart conditions, seizure disorders, orthopedic conditions; any specialized health care needs; dietary restrictions.

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Date of last T/D (Tetanus-Diphtheria Immunization): __________ Student does not have health insurance _______

Name of Health Insurance Program: ______________________ Policy #: ____________ Group/I.D. # ________

\+ **EMERGENCY AUTHORIZATION** **PARENT/GUARDIAN MUST SIGN AND DATE THIS FORM**

IN AN EMERGENCY, I HEREBY AUTHORIZE THE SCHOOL TO MAKE SUCH ARRANGEMENTS AS NECESSARY.
I ALSO AUTHORIZE THE HOSPITAL/PHYSICIAN/DENTIST TO PERFORM NECESSARY PROCEDURES.

I UNDERSTAND THAT THE COST OF MEDICAL ATTENTION AND AMBULANCE ARE THE RESPONSIBILITY OF THE PARENT.

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(Parent/Guardian Signature) (Date)

Staff administering medication: Signature ____ Initials ______________