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: _____.

Student Name: _____

Student Birthdate: _____

Student BSD ID# _____

Parent/Guardian Name: _____

Home address: _____

Phone: Home: _____

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

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

Name, phone number, and email address of two emergency contacts 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: _____
Phone: _____
Email: _____

2) Name: _____
Phone: _____
Email: _____

Permission for Emergency Medical Treatment

In the event that I/we cannot be contacted to authorize emergency medical treatment for _____ *(student name)* 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 # _____

Date: 12.18.17

Health Information: The following health conditions can be of concern. If your child has one or more condition, please describe.

Condition	Please Describe What Happens
Abnormal Bleeding	
Allergies	
Please circle type of allergy: foods, insects, medication, environmental, other	
Diabetes	
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	

Is your child physically able to take part in all trip activities? Yes ☐ No ☐

If No, what limitations are needed? _____

Will your child need to take medication on the trip, such as daily medications and/or as needed medications such as inhaler, pain reliever or allergy medications? Yes ☐ No ☐

If Yes, please follow these steps:

- All medications (prescription or over-the-counter) need to have a medication authorization form signed by a doctor and a parent (Please see 3416P Exhibit A – Medication Authorization Form).
- The completed medication authorization form must be attached to this permission form for review by the school nurse.
- If your child is able to self-carry or self-administer, the medication authorization form still needs to be signed and attached.
- If the trip is within Washington state, the medication authorization form will be kept and medication will be given by a BSD employee who is supervising the trip. If the trip is outside Washington state, please speak with the school nurse as soon as possible.
- Prescription medication must be sent in the original pharmacy container. Over-the-counter medication must be sent in the original retail container with student's name, dosage, and time to be given.

I have reviewed and understand the above information:

Parent Signature: _____

Date: 12.18.17