Tolles Career and Technical Center
District-Sponsored Overnight Trip Medical Permission Form

- Parent/guardian is to read and complete this form and return it to the School Nurse a minimum of one week in advance of the overnight field trip.
- Incomplete or non-returned forms will result in the student's exclusion from participation.
- All requests to administer prescription medication require an Ohio health care prescriber's signature.

Student's name: _____ Sex: _____ Birthdate: _____

Home address: _____ City: _____ Zip: _____

Mother/guardian's name: _____
Phone (H):_____ (W): _____ (C): _____

Father/guardian's name: _____
Phone (H):_____ (W): _____ (C): _____

Emergency Numbers (if parent/guardian can't be reached):

1. Name:_____ Phone (H):_____
   Relationship to student: _____ Phone (W):_____
2. Name:_____ Phone (H):_____
   Relationship to student: _____ Phone (W):_____

Insurance Information:

Medical insurance company: _____ Group number: _____
Insurance company address: _____
Name of policy holder: _____ Policy number: _____

Please attach a copy of the front and back of your insurance card to this form.

General Health Information:

Student's health care provider: _____ Phone: _____

If your child needs specific medical care, please attach written health care provider instructions to this form.*

Please check all that apply to your child.

☐ Animal Allergies	☐ Food Allergies	☐ Dietary Restrictions	☐ Migraines
☐ Bee/Insect Allergies	☐ Bleeding problem	☐ Asthma	☐ Glasses/Contacts
☐ Drug Allergies	☐ Mobility Concerns	☐ Seizures	☐ Hearing Aids
☐ Environmental Allergies	☐ Sleep Walking	☐ Diabetes	☐ Other_____
	☐ Activity Restrictions	☐ Heart Problem	

Please describe any medical condition, including severity and treatment._____

_____

_____

**Some students may already have health care provider instructions, school health care plans and/or prescription medication documentation on file with the nurse. This documentation is sufficient and does not need to be duplicated. Please write "see attached from the clinic" in place of the requested information. If you are uncertain as to whether or not this information is on file, please contact the nurse at 614-873-4666 x 4269.*

Non-Prescription Medication

Students in high school may self- carry non-prescription medication with parental permission. All medications must be in the original container with no other medications mixed in and must be labeled with the student's name. **Bottle recommendations for dosing must be followed**; anything else is considered to be a prescription dose, and requires the prescription medication portion of this form to be filled out by the prescribing health care provider. If permission to self-carry is not granted, any non-prescription medication presented will be kept with the trained school employee and administered per packaging instructions. If you do not wish your child to receive non-prescription medication under any circumstances, please indicate so below.

Name of drug	Dose	Times(s) to be given	Side effects

My child may self-carry the above listed medication: YES_____ NO_____

My child may not self-carry or receive non-prescription medication. _____

Prescription Medication*

If the student must take prescription medication while on the trip, the following information must be filled out and signed by the prescribing health care provider. If the student is prescribed a new medication after this form has been submitted, a note signed by the health care provider, including the dose and times to be given, must be turned in as soon as possible before the trip.

All prescription medication must be in the original container as dispensed by the pharmacist. Prescription medication, except inhalers, EpiPens and diabetic medications as noted, must be turned in to the teacher in charge of the trip before leaving on the day of the trip.

Name of drug	Dose	Times(s) to be given	Side effects

Please list any special storage instructions: _____

If the medication listed above is an inhaler, an epinephrine auto-injector, or medication and supplies for diabetic management, may the student self-carry? YES_____ NO_____

As a licensed health care provider in the state of Ohio, and at the request of this student's parent/guardian, I direct that the above medication(s) be administered as indicated.

Prescriber's printed name and title: _____

Prescriber's signature: _____ Phone: _____ Date: _____

Parent/Guardian Authorization and Emergency Consent

The information on this form is correct and complete to the best of my knowledge, and my child has my permission to participate in this event, with restrictions as noted. I understand and consent to the sharing of this information with all appropriate personnel who will be supervising my child for the duration of this trip or who may be responsible for the welfare of my child.

In the event I or another legal guardian cannot be reached in a medical or dental emergency, I consent for a school staff member to accompany my child to a medical facility. I authorize emergency medical or dental treatment by a licensed physician or dentist.

This authorization does not cover major surgeries or treatments unless the medical opinions of two other licensed physicians or dentists concur in the necessity and urgency for such surgery/treatments BEFORE they are performed.

Parent/Guardian signature: _____ Date: _____