



Form C

North East Independent School District

8961 TESORO DRIVE • San Antonio, Texas 78217

Phone (210) 804-7147, Fax (210) 804-7171

CONFIDENTIAL

Travel Consent/Health Form

STUDENT: _____ Date of Birth: _____

Insurance Coverage (Primary):

Insurance Company _____ Policy Number _____
Group Number _____ Name of Policy Holder _____

Insurance Coverage (Secondary):

Insurance Company _____ Policy Number _____
Group Number _____ Name of Policy Holder _____

Dental Coverage:

Insurance Company _____ Policy Number _____
Group Number _____ Name of Policy Holder _____

Health Related Information About Student:

List allergies to food, medications, other. If none, so state. _____

Special Health Concerns. If none, so state. _____

Date of last Tetanus vaccine. _____

Name of student's physician: _____ Office Phone: _____

Name of student's dentist: _____ Office Phone: _____

Parent/Guardian Name: _____ Relationship: _____

Phone Numbers: Home _____ Work _____ Cell _____

Parent/Guardian Name: _____ Relationship: _____

Phone Numbers: Home _____ Work _____ Cell _____

Alternate Adult Name: _____ Relationship: _____

Phone Numbers: Home _____ Work _____ Cell _____

Alternate Adult Name: _____ Relationship: _____

Phone Numbers: Home _____ Work _____ Cell _____

North East Independent School District does not assume any financial responsibility, but will arrange for emergency care. By signing this form you are giving the appropriate school personnel authority to call EMS to transport and to obtain emergency medical care.



Parent/Guardian Signature

Date



Form C







Medication Addendum to Travel Consent/Health Form

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STUDENT: _____

Permission for the Dispensing of Non-Prescription Stock Medications: Stock Medication for minor symptoms will be dispensed in accordance with dosages prescribed by the manufacturer. Dosages of other items or beyond what is prescribed on the packaging will **not be** administered.

Authorization of each must be indicated with the parent/guardian signature. No signature will be interpreted as disapproval.

<u>Medications</u>	<u>Purpose</u>	<u>Authorization</u>	<u>Parent/Guardian Signature</u>
Tylenol Acetaminophen	Fever/Pain Relief	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Advil Ibuprofen	Fever/Pain Relief Anti-Inflammatory	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Benadryl Diphenhydramine Hydrochloride	Mild Allergy	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Imodium AD Loperamide Hydrochloride	Anti-diarrheal	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Tums Calcium Carbonate	Indigestion/Antacid	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Sunscreen Lotion/Spray/Stick	Sunscreen	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	

Medications: All medications for individual students that must be taken must be brought by the student's parent/guardian to the authorized and trained district employee or authorized and trained parent (RN, LVN, MD) responsible for the student's medication. Medications must be in the original container or prescription bottle with proper labeling. All medications must have a note from the parent with specific directions in regard to dosage and times of administration. **No student may have any medications (Prescription/Non-Prescription) on their person except as described below.**

Emergency Medications/Diabetic Medications and Supplies/Prescription Birth Control Medications: Inhalers, Epipens, Glucagon Kits, Insulin and diabetic supplies or other emergency medications and prescription birth control medications are to be provided by the parents in the correctly labeled prescription container. If requested, permission for students to carry these medications for self-administration must have written physician and parent authorization. New or completed forms that have already been submitted for this purpose at school may be obtained from the school nurse.

An authorized and trained district employee or authorized and trained parent (RN, LVN, MD) will administer **all** medications not authorized for self-administration. Documentation of dates and times of administration and signatures of the authorized and trained district staff or authorized and trained parent (RN, LVN, MD) will be kept on an official NEISD Medication Administration Record.

I hereby certify that I fully understand the procedures/permission for the dispensing of Prescription/Non-Prescription Medications.

Student Signature  _____
Date

Parent/Guardian Signature  _____
Date