



**WEST CHESTER AREA SCHOOL DISTRICT**  
**EMERGENCY MEDICAL INFORMATION AND PERMISSION FORM**

(6)  
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*(Please complete pages 1 & 2 and return to the student's teacher)*

Name of Field Trip: Festival Disney Location of Trip: Orlando, Florida  
April 12-15, 2012  
 Student Name: \_\_\_\_\_ Building: East High School  
 Teacher: Ms. Huddy, Mr. de Pasquale and Mrs. Werner Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_

**IN CASE OF ILLNESS OR ACCIDENT NOTIFY THE FOLLOWING:**

PARENT/GUARDIAN INFORMATION					
Relation	Name	Employer	Work Phone #	Cell Phone #	Home Phone #
Father <input type="checkbox"/>	_____	_____	_____	_____	_____
Step <input type="checkbox"/>	_____	_____	_____	_____	_____
Mother <input type="checkbox"/>	_____	_____	_____	_____	_____
Step <input type="checkbox"/>	_____	_____	_____	_____	_____
Guardian <input type="checkbox"/>	_____	_____	_____	_____	_____

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Family Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

**ACCIDENT INSURANCE COVERAGE**

Name of Insurance Company: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Medical Conditions: \_\_\_\_\_

I give permission, at no expense to the school district or its personnel, to take my child or to transport by ambulance, to the nearest available doctor or hospital in case of medical emergency while on the above-named trip.

PARENT/GUARDIAN signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*PLEASE PROCEED TO PAGE 2\*\***  
**REVIEW IMPORTANT INFORMATION REGARDING MEDICATIONS AND THEIR**  
**ADMINISTRATION AND PROVIDE ADDITIONAL SIGNATURES**



**WEST CHESTER AREA SCHOOL DISTRICT**  
**MEDICATION ADMINISTRATION FORM**

File: IFCB-E(6)  
 First Reading

Name of Field Trip: Festival Disney Location of Trip: Orlando, Florida  
April 12-15, 2012  
 Student Name: \_\_\_\_\_ Building: East High  
 Teacher: Ms. Huddy, Mr. de Pasquale and Mrs. Werner Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_  
 Name of Parent/Guardian (please print): \_\_\_\_\_

**Please note:** We are required to have written physician orders to administer medications. Physician written orders already in place at the school nurse's office need not be duplicated. HOWEVER- doctor's signatures are required for any OTHER medications with which the school nurse has not been involved (i.e. once daily meds that are given on awakening or at bedtime). Please have him/her complete and sign below.

Some field trips will not have a professional nurse present. In that case, no over the counter medications may be given. If a nurse is going on the trip, I give permission for the nurse to give my child:

Tylenol  yes  no      Benadryl  yes  no      Advil  yes  no      Antacids  yes  no  
 on the trip as deemed necessary.

**MY CHILD REQUIRES THE FOLLOWING ESSENTIAL MEDICATIONS:**

DIAGNOSIS	MEDICATION	DOSAGE	TIME	ROUTE

**ALL MEDICATIONS MUST BE IN THEIR ORIGINAL, LABELED CONTAINERS FROM HOME.**  
**PLEASE SEND ONLY THE AMOUNT NEEDED FOR THE TRIP.**  
**DO NOT SEND LOOSE MEDS IN BAGGIES-THEY WILL NOT BE GIVEN**

All medication must be given to the nurse (or lead teacher, if there is no nurse) upon arrival to school on the day of the trip (or before). They will be turned over to the supervising adult upon departure. Medications and the signed forms must be received on or before the time of departure or will not be given.

**HEALTH CARE PROVIDER** (Pediatrician or Family Doctor):

I certify as the Health Care Provider that the above stated medications are to be given to the above named student while on the above-named trip.

\_\_\_\_\_ Date: \_\_\_\_\_  
 HEALTH CARE PROVIDER signature & phone number

**PARENT/GUARDIAN:**

I, as the parent/guardian, wish to have the above stated prescription medication(s) taken by the above named student during the above named trip.

\_\_\_\_\_ Date \_\_\_\_\_  
 PARENT/GUARDIAN signature & phone number