Louisville High School Band
Student Medical Information

Camper's Name _____ Date of Birth _____

Address _____ Phone (___) _____

Social Security Number _____

Parent or Guardian

Name _____ Home (___) _____ _____

Street _____ Work (___) _____ _____

City _____ State _____ Zip _____ Relationship to Student _____

Primary Insurance

Insurance Company Name _____

Insurance Company Address _____

Policy Number _____ Agreement Number _____

Policy Holder Name _____ Relationship to Camper _____

Secondary Insurance

Insurance Company Name _____

Insurance Company Address _____

Policy Number _____ Agreement Number _____

Policy Holder Name _____ Relationship to Camper _____

Emergency Phone Numbers

In case of an emergency, please contact one of the following individuals to give consent to treatment.

1st Choice Name _____ Home # (___) _____ Work # (___) _____

2nd Choice Name _____ Home # (___) _____ Work # (___) _____

Medical History Of Student

1. Any current medical problems?	NO	YES
2. Had any recent injury requiring medical attention?	NO	YES
3. Taken any medication recently?	NO	YES
4. Had any severe head or neck injuries	NO	YES
5. Had any major surgical operations?	NO	YES
6. Had any chronic illness (epilepsy, diabetes, heart disease)?	NO	YES
7. Any allergies or adverse drug reaction?	NO	YES

Please explain any "yes" answers _____

_____

Date of last Tetanus Immunization _____ Name of Family Physician _____

PARENTAL CONSENT TO MEDICAL TREATMENT

Please place your signature on one of the following statements concerning the medical treatment of your child.

_____

1. In the event of any illness or injury to my child, I give the attending physician permission to administer treatment, *while continuing to contact the parent, guardian or designated individual.*

_____

2. In the event of any injury or illness to my child, I DO NOT give the attending physician permission to administer treatment <u>until the parent or designed individual is contacted</u>. If you choose this option, you must contact Mr. Bleininger to explain your decision and to be more fully informed of the consequences of this decision.

Louisville City Schools
Authorization of Medication Administration

Medication Administration Record (MAR)
General Medication Form
(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name				Date of birth
Student address				
School	Grade/Class	Teacher		School year
List any known drug allergies/reactions			Height	Weight

Prescriber Authorization

Name of medication	Circumstance for use	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	
Circumstances for use		
Special instructions		
Treatment in the event of an adverse reaction		

Epinephrine Autoinjector
- ❑ Not applicable
- ❑ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Asthma Inhaler
- ❑ Not applicable
- ❑ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.

Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718
a) To the student for whom it is prescribed (that should be reported to the prescriber)

b) To a student for whom it is not prescribed who receives a dose

Other medication instructions
Does medication require refrigeration? ❑ Yes ❑ No Is the medication a controlled substance? ❑ Yes ❑ No

Prescriber signature	Date	Phone	Fax
Prescriber name (print)			

Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.

Parent/Guardian Authorization

☑ I authorize an employee of the school board to administer the above medication. ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☑ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☑ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

❑ *For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

❑ *For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

❑ File per district policy

Louisville City Schools

Certification of Authorization for Administration of Over-the-Counter Medication
Overnight Field Trip Form

DEMOGRAPHIC INFORMATION

Student's Last Name:	Student's First Name:	Student's Middle Name:
Street Address:	City:	Zip Code:
School:	Grade:	Birth Date:
Emergency Telephone Number(s):		

Does this student have any allergies to foods or medication? **Yes** **No**

If so, please list:

_____

Over-The-Counter Medication

The Louisville City Schools staff members accompanying students on the trip will have the following medications available. Please review the list and **INITIAL** next to the medication that you consent to be administered to your child. All dosages will be based on recommended manufacturer packaging instructions.

Parent Initial	Medication	Parent Initial	Medication
	Acetaminophen (ex. Tylenol)		Ibuprofen (ex. Motrin)
	Antibacterial Ointment (ex. Neosporin)		Antacids (ex. Tums, Maalox, Mylanta)
	Cough Drops/Throat Lozenges		Topical Corticosteriods (ex. Hydrocortisone Cream)
	Motion Sickness Medication (ex. Bonine)		Antihistamine (ex. Benadryl)

	If there are other OTC medications that your child might need, Please **list them below** and **initial** the box (Note: **Parent** is responsible for providing medication indicated)

Parent Guardian Authorization

Authorization to administer the above listed over-the-counter medication lasts for the duration of the trip only.

With full knowledge of emergencies, dangers, and risks related to the administration of such medication by Louisville City Schools' district employees, officers, or agents, we the undersigned, hereby waive all claims, which might arise from the said administration of such medication to said minor child and the results thereof. We agree to indemnify and hold harmless Louisville City Schools' employees, officers, or agents, from any and all liability relative to the administration of such medication.

I understand I must submit a revised statement and sign it if any information changes prior to the departure of the trip.

Parent/Guardian Signature_____

Date_____

Contact Phone #1_____ Contact Phone #2_____

Louisville City Schools Medication Form

Overnight Field Trip

STUDENT'S NAME _____

☐ *My child is NOT prescribed any medications.*

☐ *My child is prescribed medication(s).*

_____ _____

Print Student/Participant Name *Signature of Parent or Guardian*

_____

Date of Signature (REQUIRED)

****

IF THERE ARE ANY PRESCRIBED MEDICATIONS

Please complete the following.

A written statement from a licensed health professional authorized to prescribe drugs accompanied by the written authorization of the parent are required. Only medication in its original container labeled with the date, student's name, and exact dosage will be administered. Forms and prescribed oral medication must be turned into to school at least a week before the trip. Please only supply exact amount medication needed for the exact days of the trip.

Please list prescribed medication bringing:

Medication Name	***Dosage***	***Time Administered***

It is required for any student that has prescribed emergency medication (inhaler, epipen, and glucagon) to carry and use, as necessary, throughout the trip. The student must show the prescribed emergency medication to the staff member on the bus prior to departure for the trip to ensure that we have the necessary medication. Staff members have been trained on the medical needs of the child.

_____ _____

Signature of Parent/Guardian *Date(Required)*