

# 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 until the parent or designed individual is contacted. 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 <input type="checkbox"/> Not applicable <input type="checkbox"/> 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 <input type="checkbox"/> Not applicable <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No    Is the medication a controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

<input checked="" type="checkbox"/> I authorize an employee of the school board to administer the above medication. <input checked="" type="checkbox"/> I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. <input checked="" type="checkbox"/> I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.			
<input checked="" type="checkbox"/> Medication form must be received by the principal, his/her designee, and/or the school nurse. <input checked="" type="checkbox"/> I understand that the medication must be in the <b>original</b> 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**

<input type="checkbox"/> 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.			
<input type="checkbox"/> 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

# 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:

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### \*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 Corticosteroids (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 for Overnight Trips

Overnight School Trip Title and Dates: \_\_\_\_\_

STUDENT'S NAME \_\_\_\_\_

## IF THERE ARE NO PRESCRIBED MEDICATIONS

Please complete the following.

My child is NOT prescribed any medications.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date(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 Louisville City School's staff member in charge of trip a week before departure. Please only supply exact amount medication needed for the exact days of the trip.

Please list prescribed medication bringing:

Medication Name	Dosage	Time Administered

## IF THERE ARE PRESCRIBED EMERGENCY MEDICATIONS (like inhalers, epipens, glucagons...)

Please complete the following.

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 leaving for the trip to ensure that we have the necessary medication. Staff members have been trained on the medical needs of the child.

I \_\_\_\_\_ (printed name) have read and understand that my child is required to have his prescribed emergency medication with them during the Field Trip listed above. Prescription medications must be in the original, labeled container to be distributed during the trip. If there are any questions or issues that arise, I can be reached at \_\_\_\_\_ (phone number).

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date(Required)