Student Name: _____ Date: _____

Medical History

Please list below and medical problems (including any illnesses such as diabetes, epilepsy, asthma, etc.) or allergies (to medications, insect, or food):

Medical Problems: _____

_____

_____

Allergies: _____

A physician's signature needs completed by the following people…

Students aged 18 (at time of trip) bringing prescription meds on the trip
Students aged 17 (at time of trip) bringing prescription meds on the trip
Students aged 17 (at time of trip) bringing over the counter meds on the trip

Students who ARE NOT bringing medications or OTC meds DO NOT need to complete the info below

PRESCRIPTION/OTC MEDICATIONS REQUEST FORM

N.J. state law requires your doctor to sign this form and list all prescription or over the counter medications that the student will be taking on the trip, (birth control pills do not need to be listed or reported).

Physician – Please provide the following information:

Diagnosis	Medication	Dosage	Time(s) to be administered	Possible Side Effects

Please circle YES or NO – This student may attend the senior trip to Florida while taking the medication(s) listed above.

Physician Name _____
Address _____
City, State, Zip Code _____
Telephone _____

_____
Physician Signature

_____
Date

1. I grant permission for my child to self-administer medication on the trip as instructed by our physician.
2. I agree that the Kingsway Regional School District and the chaperones shall incur no liability as a result of any injury due to my child's self-administration of medication.
3. I authorize the school nurse and/or any physician to provide medical treatment.
4. I agree to the use of my insurance to cover any medical treatment.
5. I grant permission to share this information on a need to know basis
6. I agree to be responsible for all medical expenses incurred in the event I do not have insurance.

_____ _____
Parent/Guardian Signature Date

_____ _____
Student Signature Date

The student must present an original insurance card to receive medical treatment at any clinic.

Health Ins. Co.	_____	Policy No.	_____
Prescription Ins. Co.	_____	Policy No.	_____
Health Ins. Co. Phone #	_____	Prescription Co. Phone #	_____
Family Physician	_____	Physician Phone #	_____