



# 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 \_\_\_\_\_



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## Medication Addendum to Travel Consent/Health Form

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