

West Windsor-Plainsboro High School South
Medical/Emergency Information for Overnight School Trips

Please complete the following information in order to assist your student with any health problem and/or emergency.

Student's Name _____ Date of Birth _____
(Last) (First)

Address _____

Student's Cell Phone _____

Father _____ Home Phone _____ Cell Phone _____

Mother _____ Home Phone _____ Cell Phone _____

Student's desired t-shirt size (XL, L or M) _____

If unable to reach parent in case of emergency, contact

Name _____ Phone No. _____

Family Physician _____ Phone No. _____

Insurance Company _____ Policy Number _____

1. Is the student presently under the care of a physician for any particular reason? If yes, please explain.

2. Is there any medical limitation or condition that would affect your student on this trip? If yes, please explain.

3. Does the student have any known allergies? Yes _____ No _____ If yes, please explain

4. Is there any medication, including over the counter medications that your student needs to take while on this trip? Yes _____ No _____ If yes, what medication and for what reason? _____

Note: All medication in students' possession must be supplied in the original container and appropriately labeled.

I relieve the West Windsor-Plainsboro Board of Education and its employees of any liability for the benefits or consequences arising from the self-administration of the medication by the student. I also understand that the self-administration privilege shall be revoked if it is deemed that my son/daughter has failed to comply with school policy and tenets of the agreement to self-medicate.

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, the administrator in charge has my permission to obtain the services of a physician and/or hospital until I can be contacted.

Parent/Guardian Signature _____ Date _____



WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

West Windsor-Plainsboro High School South
346 Clarksville Road, P.O. Box 535
Princeton Junction, New Jersey 08550-0535
Phone: (609) 716-5050
Fax: (609) 897-7372
Nurse: Extension 7306

Anneclaire Kasper
Kris Grabell
School Nurse

Dear Parent/ Guardian,

A Medication Form completed by the medical doctor and signed by a parent must accompany all medications taken on a school trip, including "over the counter" and prescription medication. The only exception are birth control pills; no medication form is required. If we do not have a doctor's form, the student will not be able to take the medication.

Students are not allowed to carry medication in their luggage or on their person.

The only exceptions are medications needed for life threatening conditions, which maybe self administered, such as inhalers, benadryl or epipen for an allergy, or diabetic medication. These medications, along with birth control pills, may be carried by the students in their carry-on bags

No vitamins or supplements are allowed on any school trip.

In the morning, a nurse will be available so students can come one at a time, to maintain their privacy, for medication. We will not go and look for a student unless the medication is essential. The same procedure will hold for any medication needed at nighttime. If medication is needed during the day we'll make special arrangements with individual students.

All medication, OTC & prescription, must be in original bottles or packs labeled with the students name. Turn in medication forms, along with just enough medication in a labeled original container a week prior to the trip.

We do have standing orders, from the school physician, for Tylenol or Benadryl, and may give these medications as needed. Of course, if your child is very sick or has any other problem we will call you. We will have basic first aid supplies with us.

If you have any questions please call the health office.

Sincerely,

Anneclaire Kasper, RN

Kris Grabell, RN



WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

West Windsor-Plainsboro High School South
346 Clarksville Road, Princeton Junction, New Jersey 08550

Phone 609-716-5050 ext.7306
Fax 609-897-7372

Anneclaire Kasper
Kris Grabell
School Nurse

Prescription Form for Administration of Medication in School

Student's Name _____ D.O.B. _____ Grade _____

Diagnosis _____

Name of Medication _____ Dosage _____

Time and Circumstances of Administration _____

Possible side effects: _____

Length of time the prescription is valid _____ (May not exceed the school year)

When specific guidelines are followed, a student may self-administer medication. Self-administration of a prescribed medication is permitted only in exceptional circumstances when a life threatening condition exists. For purposes of the Board policy life threatening illness is defined as, "...an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use of an inhaler to treat an asthmatic attack or the use of an adrenaline injection to treat a potential anaphylactic reaction."

When self-administration of medication is applicable for a life threatening condition and in accordance with West Windsor-Plainsboro School District policy guidelines are as follows:

- Grades K-3 – No student will be allowed to self-administer medication without the assistance of a nurse.
- Grades 4-5 – A student will be allowed to use inhalers without nurse assistance on field trips only.
- Grades 6-12 – A student may self-administer medication for life threatening illnesses.

_____ is capable and has been instructed in the proper method of
Student's name

self administration of _____ as directed.
Medication

When an auto-injector is prescribed, please provide the following information:

Is there a documented history of anaphylaxis? Yes _____ No _____

If yes, please provide the signs/symptoms of this child's anaphylactic episode(s) _____

SIGNATURE OF PHYSICIAN/DENTIST **DATE** **PHONE**

PHYSICIAN/DENTIST NAME (PRINT/TYPE/STAMP)

WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

Parent Permission for Administration of Medication in School

Student's Name _____ D.O.B. _____ Grade _____

Administration of medication during school hours **is not** encouraged. However, if a physician determines that failure to take medication would jeopardize the health or school attendance of a student, the medication will be given by the school nurse. In so doing, the West Windsor-Plainsboro Board of Education and its employees shall incur no liability for any benefits or consequences occurring from the administration of the medicine.

I hereby request that the school nurse administer _____ as directed by my
Name of Medication
physician. I will supply the medication in its original container and personally deliver it to the school nurse.

When applicable and in accordance with the West Windsor-Plainsboro School District's policy, I give permission for my son/daughter to self-administer the above medication. I also understand that the self-administration privilege shall be revoked if it is deemed that my son/daughter has failed to comply with school policy and tenets of the agreement to self-medicate.

I relieve the West Windsor-Plainsboro Board of Education and its employees of any liability for the benefits or consequences arising from the administration or student self-administration of this medication.

Signature of Parent/Guardian

Date

Parent/Guardian Name (Print/Type/Stamp)