



# North East Independent School District

8961 TESORO DRIVE – SAN ANTONIO, TEXAS 78217  
Phone (210) 407-0304, Fax (210) 804-7171

**CONFIDENTIAL**

Department of  
Health Services

## *Medication Addendum to Travel Consent/Health Form*

**Permission for the Dispensing of Non-Prescription Medications:** 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/Acetaminophen</b>	Fever/Pain Relief	Yes	No	
<b>Advil/Ibuprofen</b>	Fever/Pain Relief/ Anti-Inflammatory	Yes	No	
<b>Benadryl/ Diphenhydramine Hydrochloride</b>	Mild Allergy	Yes	No	
<b>Imodium AD/ Loperamide Hydrochloride</b>	Antidiarrheal	Yes	No	
<b>Tums/Calcium Carbonate</b>	Indigestion/Antacid	Yes	No	

**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, PA, Pharmacist) responsible for the student’s medication. Medications must be in the original container or prescription bottle with proper labeling. All medication 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 RN.

An authorized and trained district employee or authorized and trained parent (RN, LVN, MD, PA, Pharmacist) 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, PA, Pharmacist) will be kept on an official NEISD Travel Medication Record.

I hereby certify that I fully understand the procedures/permission for the dispensing of Non-Prescription/ Prescription Medications.

**Student Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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Health Services

### Travel Consent/Health Form

**STUDENT:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Insurance Coverage:**

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 \_\_\_\_\_ Pager \_\_\_\_\_

**Parent/Guardian Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Pager \_\_\_\_\_

**Alternate Adult Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Pager \_\_\_\_\_

**Alternate Adult Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Pager \_\_\_\_\_

*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**