Lovejoy High School
Medication Administration For Field Trips

Student Name:_____Date:_____

Parent / Guardian_____Phone:_____

Medication Allergies:_____

The Teacher / Coach in charge of the trip will collect, maintain, dispense medications provided by parents. Lovejoy ISD does not provide medications of any type (including Tylenol, Ibuprofen, TUMS, etc).

No pills in baggies will be accepted, all medications must be in the original container. No expired medications will be accepted. Inhalers must have prescription label on the inhaler or box. Prescription medications must be in the original container with the pharmacy label clearly indicating how medication is to be utilized. For documentation purposes prescription medications will be counted by Coach and parent.

Medication Name:_____To be given for:_____

Dosage / Amount to give:_____How often:_____
Given: _____

_____

Medication Name:_____To be given for:_____

Dosage / Amount to give:_____How often:_____
Given: _____

_____

Medication Name:_____To be given for:_____

Dosage / Amount to give:_____How often:_____

Given: _____

_____

Coach / Teacher will date, time, and sign each time med given.

Lovejoy Independent School District
STUDENT HEALTH INFORMATION

In an effort to provide safe, informed care for your child at school, the LISD Health Services Department requires the following information to complete your child's enrollment. Medical information you provide about your child is a confidential education record. LISD keeps all medical information about your child confidential as required by the Family Educational Rights and Privacy Act and other applicable law. However, health information about your child will be communicated to LISD school personnel who require the information to better serve your child.

Note: **Parent must update this health information form as needed to indicate any change in the health status of the student.**

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StudentName_____

Last First Middle

Birth date_____ Gender (circle one): M F Grade_____

Teacher_____

Mother name_____ Cell # _____Home #_____Work # ____

Father name _____Cell#_____ Home# _____Work#_____

Parent Email

_____

Please mark any of the following that apply:

____ **MY CHILD HAS NO KNOWN HEALTH CONDITIONS**

____ MY CHILD HAS NO KNOWN FOOD or MEDICATION ALLERGIES

HEALTH CONDITIONS:

Yes / No Allergies (medications, foods, insects, etc)
If yes, to what?
_____
Symptoms of reaction? (hives, difficulty breathing)
_____
What kind of treatment?
_____
Yes / No Epi Pen
Yes / No Seizure Disorder. If yes, what kind?_____
What kind of treatment?
_____
Yes / No Diabetes
Yes / No Glucose testing?
Yes / No Respiratory Condition? If yes, how is it managed?
_____
Yes / No Other medical concerns:_____
_____
Insurance information, please attach a copy of insurance card: _____
_____

Parent/Guardian Signature_____Date_____