Overnight Field Trip Authorization and Personal Health History Form

This information and consent applies to the following:

Type of field trip and destination: _____

Teacher/grade level: _____ Date(s) of trip: _____

Student's name: _____ DOB: _____

Address: _____ Phone (Home/Cell): (____) _____

Parent/Guardian: _____ Phone (Home/Cell/Work): (____) _____

Alternate Emergency Contact: _____ Phone (Home/Cell/Work): (____) _____

Health Care Provider: _____ Phone: (____) _____

Health Insurance Co.: _____ Policy #: _____

Policy Holder: _____

Health History Information:

Allergies (please specify):

Food: _____ Drug: _____ Bee Sting: ____ Other: _____

Seizures (list type): _____ Date of last Td shot: _____

Please ✓all that apply:

Asthma	_____	ADD/ADHD	_____	Nightmares	_____
Diabetes	_____	Stomach aches	_____	Bed wetting	_____
Heart Condition	_____	Ear infections	_____	Sleepwalks	_____
Has had first Menstruation	_____	Faints easily	_____		
Sensitivity to Poison Ivy	_____	Sumac	_____	Oak	_____

Has your child been recently exposed to a communicable disease within the past 21 days? Yes No

If yes: please explain: _____

_____

Is there any reason to limit your child's activity? Yes No

If yes, please explain: _____

Please describe any other special health conditions, information, or directions regarding care needed: _____

_____

_____

_____

_____

_____

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_____

If your child requires any medications *(prescription or over the counter)* **on the field trip, the "Parent/Guardian Request" section of this form must be completed and returned to school by** *(date)*: _____. **School policy does not allow students to self-medicate or carry drugs except in special situations.**

911 or Emergency Medical Services will be called in the event of a medical emergency and the student will be transferred to the nearest medical facility.

I hereby give permission for emergency care to be secured by the school staff and understand that, should a medical emergency arise, every effort will be made to contact me before such care is given. We understand the arrangements described for this and believe that the necessary precautions/plans for the care and supervision of the students will be taken during this trip. Beyond this, we will not hold the school or those supervising the trip responsible. I do give consent for my child to go on this trip.

Parent/Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

Medication Form for Overnight Field Trips:

The administration of any medication to students on any field trips shall be done only when the student has a medical condition that may be adversely affected without medication. This applies to both prescription and nonprescription medication.

Prescription medication **MUST** come in the pharmacy labeled container with the student's name, pharmacy and telephone number, name of physician, drug name, dosage and time to be given. Nonprescription medication **MUST** come in its original container and be labeled/marked with the student's name.

- **This medication form must be completed and returned to school by** *(date)*: _____
- The parent/guardian is responsible for bringing all medications needed on the field trip to the nurse by *(date)*: _____
- **This deadline for medication delivery is absolute** and must be followed in order for safe planning and procedures for the trip. Send only the amount of medication needed for the length of the field trip. School policy does not allow students to self-medicate or carry drugs except in special situations.

Parent/Guardian Request:

I request that the following medications be given to my child while participating in the field trip. I release school personnel from any liability in relation to the administration of these medications. I authorize the reciprocal release of information related to medication between the nurse and the prescribing health professional.

Parent/Guardian Signature: ______________________ Date: ____________

Name of prescriber of these medications: ______________________

Phone of prescriber: (____) ______________

Medication: ______________________ Dosage: ____________
Time: __________ AM/PM Time: __________ AM/PM Time: __________ AM/PM
Side effects to watch for: ______________________

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Time: __________ AM/PM Time: __________ AM/PM Time: __________ AM/PM
Side effects to watch for: ______________________

Medication: ______________________ Dosage: ____________
Time: __________ AM/PM Time: __________ AM/PM Time: __________ AM/PM
Side effects to watch for: ______________________

For the following conditions: ______________________

Licensed Prescriber Order:

I have prescribed the above medication(s) for this child and request the dosages be given at the indicated times.

Prescriber's Signature: ______________________ Date: ____________

Phone of prescriber: (____) ______________

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