

Adams County School District #14

Name of School _____

Field Trip Date _____

Address of School _____

Phone Number of School _____

Field Trip Destination _____

School Clinic Phone Number _____

Student Health Information for Overnight Field Trips

All students must have this form completed and returned by _____. Any student without the information **will not** be allowed to participate in the field trip.

Medication cannot be administered without a Medication Authorization form on file signed by you and your child’s health care provider. This includes all over-the-counter and prescription medications. If your child takes medications at school, the current orders are valid for the field trip. If your child takes medications outside school hours, new medication authorizations are needed. Prescription medications must be provided in pharmacy bottles labeled with your child’s name or in the original package if over-the-counter medications. Medication Authorization forms may be obtained in the school clinic. If your child obtains a new prescription the week of the trip, please inform the school clinic immediately.

Return in the Medication Authorization form(s) and medication(s) to the health clinic by _____.

There will NOT be a registered nurse on the trip. Medication will be administered by a trained staff member. Please make sure that we have a number where we can contact you if your child becomes ill or if we need your assistance during the trip.

Student Information

Student Name _____

Date of Birth _____

Address _____

Home/Cell Phone _____

Physician’s Name _____

Phone _____

Health Insurance _____

Policy # _____ Group # _____

Medicaid # _____

Emergency Telephone Numbers

Mother’s Name _____

Home/Cell # _____ Other # _____

Father’s Name _____

Home/Cell # _____ Other # _____

Guardian _____

Home/Cell # _____ Other # _____

Other Contact _____

Home/Cell # _____ Other # _____

Other Contact _____

Home/Cell # _____ Other # _____

Call (name of health clerk), Health Clerk at (phone number) if you have any questions.

Name of Student _____ Date of last tetanus _____

Please list any significant health problems your child has that the staff should be made aware of, for example asthma, heart condition, emotional, or other health concerns. List the health concern, what to expect, and what we can do to assist your child. _____

List any allergies (drugs, food, insect, other) _____

What type of reaction has your child had in the past? _____

Does your child have any fears we need to be aware of on the trip? _____

Any information regarding your child (bedwetting, sleepwalking, homesickness, etc.) and how you prefer we assist your child _____

Medications

_____ No, my child will not be taking any medication.

_____ Yes, my child will require medication during the field trip. **(Must have a written order from your child's health care provider)**

Medication	Dose	How Given	What Time or As Needed

Further Instructions _____

In the event your child becomes ill or injured while on the field trip, we will make every effort to reach you. If your child needs to be transported home, it will be your responsibility to transport your child. If your child needs immediate emergency medical attention, any costs incurred are the responsibility of the parent/guardian.

I give permission for school personnel to seek emergency medical attention for my child in my absence.

Signature of Parent/Guardian _____ Date _____