Wachusett Regional

**Overnight Field Trip Health Form**

School:______________________________________________Grade:_______Teacher:____________________
Destination:__________________________________________________________ Trip Date:_______________

**Student Name:**___________________________________________________ DOB:___________________
Address: ___________________________________________________________________________
Home Phone: ______________________________ Cell Phone:_________________________________

List Emergency Telephone numbers where you can be reached and the hours you would be available at these numbers.

| Mother:_____________________________________ | Father:_____________________________________ |
|---|---|
| Home:_____________________________________ | Home:_____________________________________ |
| Cell:_____________________________________ | Cell:_____________________________________ |
| Work:_____________________________________ | Work:_____________________________________ |

* Please notify the following person in the event that I cannot be reached in an emergency:

| Name | Relationship | Phone |
|---|---|---|
| | | (H) (C) |
| | | (H) (C) |
| | | (H) (C) |

**Health History**: Please note any of the following conditions, which apply to your child:

| Asthma: Y N | Emotional/Anxiety: Y N | Migraine Headaches: Y N |
|---|---|---|
| Diabetes: Y N | Seizure: Y N | Concussion: Y N |
| Heart Condition: Y N | Muscular/Skeletal: Y N | Other: |
| Seizure disorder: Y N | ADHD: Y N | |

Date of most recent TETANUS SHOT: ________________Please list any medical restrictions or limitations to your child's physical activities:_________________________________________________________

**Note: All medication both <u>prescription</u> and <u>non-prescription</u> that is to be administered to your child must be authorized by the student's physician in the Physician's Written Orders below.**

**<u>Physician's Written Orders</u>**

**The following section of this form is to be completed by the student's physician.** Please include all medications including prescription and/or non-prescription medication that will be **NECESSARY** for the student to **self administer** during the course of the field trip (dates) ________________ to _______________ . **Please include medication name, dosage, frequency and time to be given.**

| **Medication** | **Dosage** | **Frequency** | **Route** | **Time(s) to be given** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Physician's Signature**_____________________________________________________ **Date** __________________

Physician approves the student to **self administer** the listed medications.

**Physician Signature** ____________________________________________________**Date**_________________

**Self Administration Agreement**
(Agreement between Parent, Physician, Nurse & Staff)
-Student is able to recognize his/her own medications/confirms labeling.
-Student knows dosage, understands proper use of the medication, knows proper time and frequency to use the medication and has used the medication before.
-Student will document on the medication log that they took the medication and at what time.
-Student will not share his/her medication with any other student.
-All medications supplied by the parent/guardian are for that student only.

**If no nurse is present on the field trip:**
School staff will transport and securely store all controlled medications except for inhalers and Epi-Pens. (A student requiring an inhaler or Epi-Pen will carry his/her own inhaler or Epi-Pen).
-Student will get his/her medication from the staff at the correct time.
-Staff will have a list of student medications and time to be administrated.
-Staff will be responsible for student documentation that the medication was taken.
-Staff is trained in Epi-Pen administration and is able to recognize signs of an allergic reaction.
-Staff is knowledgeable when to assist student or give Epi-Pen injection. **911 will be called immediately if an EpiPen is given.**

My son/daughter is able to consume or apply the listed prescription or non-prescription medication in the manner directed by the licensed provider without additional assistance or direction. I hereby give my child permission to self administer the approved medication.

**Parent Signature** ________________________________________________________ **Date**_________________

Comments
-_______________________________________________________________________________________________

_______________________________________________________________________________________________

School nurse approves the student to self administer the listed medications.

**Nurse Signature** ___________________________________________________________**Date**_______________

Comments
-_______________________________________________________________________________________________

_______________________________________________________________________________________________

In the event of an emergency, I hereby authorize the school administrator to seek emergency medical care for my child.

**Parent/Guardian Signature**__________________________________________________ **Date** _________________