INDEPENDENT SCHOOL DISTRICT 110
Waconia Public Schools

FIELD TRIP and STUDENT TRAVEL – HEALTH FORM

Student Name: _____ **Date of Birth:** _____

Field Trip Destination: _____ **Teacher/Advisor:** _____

Emergency Contact Information:

1. Name:_____ Relationship:_____
   Home Ph:_____ Work Ph:_____ Cell Ph:_____

2. Name:_____ Relationship:_____
   Home Ph:_____ Work Ph:_____ Cell Ph:_____

Medical Information:

- Please fill out this section in detail, although this medical information may have been disclosed in previous years, please note all information needed on this form that is necessary to care for your child.
- You may refuse to disclose this personal medical and medication information, however without this information the school district may not be able to properly care for your child during a medical emergency,

Health Conditions: _____

_____

Allergies:_____ Dietary Needs:_____

Family Physician:_____ Ph:_____ Location:_____

Health Insurance Company:_____ Policy #:_____

Is your child currently taking any medication(s)? ☐ Yes **(If yes, complete page two)** ☐ No
Please list medications:_____

_____

If your child requires ANY MEDICATION *(over-the-counter and/or prescription)* on the field trip please complete the *Medication Administration for Field Trip and Student Travel* form on page two.

Parental Consent/Responsibility Clause/Medical Permit

I give permission to School District 110 to make whatever emergency measures are judged necessary for the care and protection of my child. In case of a medical emergency, I understand that my child will be transported to the nearest medical facility, and if local emergency resources (police, rescue squad) deem it necessary, the child will be transported at the expense of the parent. It is understood that in some medical situations, the staff will need to contact the local emergency resource before the parent and/or other adult acting on the parent's behalf. I understand that health staff do not routinely accompany students on field trips and that other trained faculty/staff members will be responsible for managing student health needs and medication administration.

I give permission for the above health/emergency information to be shared with appropriate school personnel to meet my child's health and educational needs.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

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Medication Administration – Field Trip and Student Travel

This form goes along on all destination tours/activities. Please, fill out completely.

Student Name: ______________________________________ **Date of Birth:** _________________

School District 110 acknowledges that some students may require prescription and over-the-counter medications to be administered during field trips and student travel. For parents requesting medication to be administered during field trips and student travel, parents must provide ISD 110 the following:

- Medication(s) in an appropriately labeled container, over-the-counter medications must be in original container(s) and prescription medications in a prescription bottle.
- Parent/Guardian permission and signature and physician/licensed provider signature.
- Students are allowed to self-carry the following medications if parent/guardian signs authorization to self-carry and student understands his/her responsibility of self-carrying **(prescription asthma medications, prescription epinephrine, and non-prescription pain relievers in a manner consistent with labeling)**. *See Authorization to Self-Carry Section Below.*
- ISD 110 **WILL NOT** provide any stock medications including aspirin, acetaminophen, ibuprofen, cough drops, etc.

Medications: Chaperone Administered / Student Self-Carry

Medication:____________________________ Dose:_____________ Frequency:_________________ ☐ ☐

Staff use only - Date, Time and Dose of Medication Administrated & Initials of Person Giving Medication:

Medication:____________________________ Dose:_____________ Frequency:_________________ ☐ ☐

Staff use only - Date, Time and Dose of Medication Administrated & Initials of Person Giving Medication:

Medication:____________________________ Dose:_____________ Frequency:_________________ ☐ ☐

Staff use only - Date, Time and Dose of Medication Administrated & Initials of Person Giving Medication:

Medication:____________________________ Dose:_____________ Frequency:_________________ ☐ ☐

Staff use only - Date, Time and Dose of Medication Administrated & Initials of Person Giving Medication:

Medication:____________________________ Dose:_____________ Frequency:_________________ ☐ ☐

Staff use only - Date, Time and Dose of Medication Administrated & Initials of Person Giving Medication:

Physician/licensed prescriber signature: ____________________________________ **Date:** __________________________

Print Name of Prescriber: ___________________________ **Clinic:** ________________ **Phone:** _________________

Authorization to Self-Carry

Parent/Guardian and student agree and understand that student will:

- Follow health care provider's orders
- Not allow other students to use medication
- Will adhere to prescription and over-the-counter label instructions
- Keep medication in (e.g. purse, backpack, suitcase, etc.) _____________________
- Alert ISD 110 staff if symptoms persist, side effects from medication, and/or any questions regarding medication

I/(We) request and authorize my child to be responsible to self-administer the above listed medication(s) during this event; thereby, releasing school personnel and chaperones from liability should inappropriate usage and/or restrictions result from the medication(s). **Yes**___ **No**___

I understand that medications must be carried in the original (labeled) container and that any prescription and non-prescription medications must be listed on this form.

Parent/Guardian Signature:____________________________________ **Date:**_____________________