Overnight Field Trip Health Form

To be completed by school staff

Form due by: ____/____/____ Medication due to health office: ____/____/____ Teacher(s) in charge: _____

Date(s) of trip: ____/____/____ ____/____/____ Field trip destination: _____

To be completed by parent/guardian

Student name: _____ Date of birth: ____/____/____ Student ID#: _____

Address: _____ Parent/guardian 1: _____ Phone number: (____) _____

_____ Parent/guardian 2: _____ Phone number: (____) _____

Health Information

Place an "x" or ✓ in the appropriate box to answer "Yes" or "No"

My child will take medication or require a healthcare procedure on this field trip.	☐ Yes	***(If Yes, complete page two)***	☐ No
Does your child have any allergies to insect stings/bites, food, latex, etc.?	☐ Yes	If Yes, please list below:	☐ No
Does your child require medication to treat severe allergic reactions to insect stings/bites, food, etc?	☐ Yes		☐ No

Does your child:

have Seizures	☐ Yes ☐ No	have Asthma	☐ Yes ☐ No	have Diabetes	☐ Yes ☐ No
have a heart condition	☐ Yes ☐ No	wet the bed	☐ Yes ☐ No	sleepwalk	☐ Yes ☐ No

Does your child have any other health condition that could result in an Emergency?	☐ Yes	If Yes, please list below:	☐ No
Are there any other health conditions we should be aware of?	☐ Yes	If Yes, please list below:	☐ No

I give permission for school staff to seek care for my child in the event of an emergency. I understand that every effort will be made to contact me before emergency care is given. I understand that my responses on this form will authorize arrangements to be made for the care and supervision of my child. I release Saint Paul Public Schools and its insurers, together with past and present Saint Paul Board of Education (BOE) members, directors, officers, employees, volunteers, and the agents and successors of each from, any and all claims, causes of actions, and/or liability of any kind in relation to any and all emergency medical care sought, given to, or received by my child. I understand that this health information will be shared with school staff accompanying my child on this field trip.

Parent/guardian signature: _____ **Date**: ____/____/____

(Complete page 2 if your child will take medication or require a health care procedure on this field trip)

Overnight Field Trip Medication/Procedure Authorization

To be completed by parent/guardian

Student name: _____ Date of birth: ____/____/____ Student ID#: _____

Medication and health care procedures will be provided only when a student's health condition will be negatively affected without treatment. This applies to both prescription and non-prescription medication.

Prescription medication MUST come in the pharmacy labeled container with the student's name, pharmacy and telephone number, prescriber's name, drug name, dosage and the time of day that it should be given *(dosing schedule)*.

Non-prescription medication MUST come in its original container with the manufacturer's instructions and be labeled/marked with the student's name.

Parent/Guardian Request

I request that the following medication(s) and/or procedure(s) be given to my child on this field trip. I release Saint Paul Public Schools and its insurers, together with past and present Saint Paul Board of Education (BOE) members, directors, officers, employees, volunteers, and the agents and successors of each from, any and all claims, causes of actions, and/or liability of any kind in relation to the administration of these medications/procedures. I authorize the reciprocal release of information, including, but not limited to, private educational data and private health information, related to medication and/or procedure between the nurse and the prescribing health professional.

Parent/guardian signature: _____ **Date**: ____/____/____

Medication/Procedure	**Dose Amount**	**Time of Day to be Given** *(dosing schedule)*	**Prescriber Name and Phone Number** *(include Area Code)*