

# Student Packet

## for

*Overnight*  
*Out of State*  
*Out of Country*  
Field Trips

Parent/Guardian / Health Care Provider / Trip Nurse

Please complete this packet and return the packet to your teacher in charge of the field trip.

Student will not be allowed to participate in the trip without a completed packet.

**CONCORD-CARLISLE HIGH SCHOOL**  
**OVERNIGHT / OUT OF STATE /OUT OF COUNTRY FIELD TRIP FORM**

To be filled out for overnight or out of state trips.

**Parents/Guardians' Permission and Release Form**  
**(For Overnight Field Trips and Out of State Trips)**

I/We \_\_\_\_\_ of \_\_\_\_\_  
Print name of Parent/Guardian Town of Residence

Parent/guardian of \_\_\_\_\_, a minor who is a student in the class of \_\_\_\_\_ at \_\_\_\_\_  
Print Name of Student YOG

Concord-Carlisle High School, Concord, Massachusetts, hereby grant permission to the Town of Concord and Carlisle, its School Committees and its employees and agents for our minor child to participate in a school trip to \_\_\_\_\_  
Location of trip

It is my/our understanding that \_\_\_\_\_ as well as other chaperones, will accompany the group.  
Head Chaperone

In consideration of the education value of travel, and other privileges and advantages to be gained by my/our child's participation in said trip, I/we do hereby forever release, acquit, discharge and covenant to hold harmless the Town of Concord and the Town of Carlisle, its School Committees, its employees and agents and their employees who are accompanying the students on the aforementioned trip, from all actions, causes, of actions, claims, demands, damages, loss of services, expenses and compensations on account of, or in any way growing out of any and all personal injuries and property damage which may result at any time during the trip, and which we may hereafter have as parents and/or guardians of said minor child, as well as all claims or rights of action for damages which the said minor child may hereafter have either before or after he/she has reached majority. I/We further promise to bind myself/ourselves jointly to reimburse to said releases any sum of money which it/they may be compelled to pay because of any injury or damage or for any other reason, on be half of said student while on said trip.

I/We further agree that should said minor child \_\_\_\_\_  
Name of Student

behave in a manner which, in the judgment of the teacher in charge, may endanger the health, safety or welfare of that student or others in the group (this of course includes any infraction of alcohol/drugs, rule), the teacher in charge in his/her sole discretion has my/or permission to the following:

1. Space will be reserved on the next available flight returning to Boston, and my/or child will be placed on such flight;
2. I/We shall be totally responsible for reimbursing any and all expenses for such transportation;
3. Upon notification of such decision, I/we agree to meet and be responsible for my/our child upon his/her arrival.

I/We are aware that my/our minor child has been advised to travel in groups and is expected to maintain a buddy system during unscheduled time periods.

\_\_\_\_\_  
Signature - Name of Adult Print Name of Adult (Mother/Father/Guardian)

\_\_\_\_\_  
Print Address of Adult (Mother/Father/Guardian)

**If the student is 18 years or older in age - Student must read the foregoing and sign below**

I, \_\_\_\_\_, a student at Concord-Carlisle High School, have read the Permission and release form and agree to its contents.

\_\_\_\_\_  
Student Signature / Print Student Name Date \_\_\_\_\_

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**Student Contract - Code of Conduct**

1. I agree to follow all school rules and regulations as stated in the student handbook.
2. I will not be in possession of or utilize drugs, tobacco, and/or alcohol while traveling with Concord-Carlisle High School student group. I also agree not be found in the presence of such substances or I will be found equally at fault.
3. I agree to abide by the curfew rules set. At the appointed time, I will go to my room and observe quiet. Bed checks may occur after curfew and ensure that the students are where they are supposed to be.
4. I agree to uphold all laws and regulations as dictated by local governments (e.g. underage drinking, assault, shoplifting). I agree to respect the property of others and to pay for any losses and/or damages for which I am found responsible.
5. I agree never to leave the hotel without permission from my chaperone. Should I be granted permission to leave, I will be accompanied at those times by other members of my group. I will fill out the student log book following the detailed procedure.
6. I understand that I am under the direct responsibility and authority of (Teacher's Name)\_\_\_\_\_

I am signing this Contract, and hereby giving my Word of Honor that I will follow the above Code while traveling with the Concord-Carlisle High School group on \_\_\_\_\_  
Date(s) of trip.

As a representative of Concord-Carlisle High School, I understand that my behavior is critical to the success of the trip and as a precedent for future tours. Any violation of these rules will result in disciplinary action.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Date

**I HAVE READ THE ABOVE CONTRACT SIGNED BY MY CHILD.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Print Parent Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Print Parent Name

\_\_\_\_\_  
Date

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**EMERGENCY CONTACT INFORMATION**  
**&**  
**PARENT/GUARDIAN CONSENT FORM FOR EMERGENCY MEDICAL TREATMENT**

|                                   |                                        |
|-----------------------------------|----------------------------------------|
| <b>Minor's Name</b>               | <b>Date of Birth</b><br>Month/Day/Year |
| Last _____ First _____ M.I. _____ | / /                                    |

In the event of an emergency situation, I give (Teacher's Name) \_\_\_\_\_, designated chaperones, or trip nurses permission to sign consent for medical treatment for my minor child named above.

I also give permission to release medical information to emergency care providers or other appropriate health care providers in order to treat my child in a medical emergency

I also agree that I will be responsible to pay out of pocket medical expenses incurred if emergency treatment is needed.

**Optional Information:**

|                             |              |                  |
|-----------------------------|--------------|------------------|
| Significant Allergies _____ | Health _____ | Issues _____     |
| Current Daily _____         |              | Medication _____ |
| Dietary Concerns _____      |              |                  |

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Print Parent Name

\_\_\_\_\_  
Date

|                                                                                                                                |                    |              |
|--------------------------------------------------------------------------------------------------------------------------------|--------------------|--------------|
| <b><u>Emergency Contacts in Order of Contact – These Numbers will be effect during the trip.</u></b><br>(Please Print Clearly) |                    |              |
| Name _____                                                                                                                     | Relationship _____ | Home # _____ |
| Email address _____                                                                                                            |                    | Cell # _____ |
|                                                                                                                                |                    | Work # _____ |
|                                                                                                                                |                    |              |
| Name _____                                                                                                                     | Relationship _____ | Home # _____ |
| Email address _____                                                                                                            |                    | Cell # _____ |
|                                                                                                                                |                    | Work # _____ |
|                                                                                                                                |                    |              |
| Name _____                                                                                                                     | Relationship _____ | Home # _____ |
| Email address _____                                                                                                            |                    | Cell # _____ |
|                                                                                                                                |                    | Work # _____ |

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**Family Insurance Coverage**

In the event of an emergency involving hospital care and/or specialist consultation, we will use your family's health insurance policy for your child.

Student Name \_\_\_\_\_  
Please Print Clearly

Name of Insurance Company \_\_\_\_\_  
Please Print Clearly

Address of Insurance Company \_\_\_\_\_  
Please Print Clearly \_\_\_\_\_  
\_\_\_\_\_

Telephone # of Insurance Company \_\_\_\_\_

Name of Head of Household/Policy Holder \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Other Pertinent Information  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMPORTANT:**

Please photocopy both sides of your health insurance card in the space below or you may attach a copy of both sides of your card to this form. We suggest you contact your insurance company to verify coverage for any out of country trip.

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**TO BE COMPLETED BY HEALTH CARE PROVIDER OR**  
**ATTACH CURRENT PHYSICAL AND IMMUNIZATIONS IF NO**  
**MEDICATIONS ARE NEEDED**

**HEALTH CARE PROVIDER STATEMENT (required for all student):**

I certify that \_\_\_\_\_, DOB \_\_\_\_\_, had a  
physical on \_\_\_\_\_. The last tetanus shot is dated \_\_\_\_\_.

At this time, there are no limitations that would prevent travel to \_\_\_\_\_  
Location of Trip  
and pursuit of an active schedule while there. The immunizations record is attached.

**Health Care Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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PHYSICIAN ORDERS AND PARENT CONSENT  
PRESCRIPTION AND OVER-THE -COUNTER MEDICATION — Essential for this trip

Student's Name \_\_\_\_\_ Date \_\_\_\_\_

Orders for prescription and non-prescription medication and special procedures for a student on a trip must be written below by a licensed health care provider. With written physician order\*, (see below) written parent consent and R.N. approval a student may self-administer medication. The attached permission form must be signed for self-administration. Only the amount of medication needed on the trip in its original or prescription labeled container is to be included.

Pharmacy labels must be intact and accurate. Medications not approved for self-administration will be administered by or under the supervision of a nurse or a staff member trained by the school R.N.

Medications that are not in their original bottles cannot be dispensed. All medications, including vitamins and over-the-counter medicines including Tylenol and ibuprophen must be written and signed for by a medical practitioner on this sheet.

**\*Written Physician Order Listed Below: Must be completed by the student's physician.**

| Medication | Purpose | Dose | Time to be taken | Important Information | Approved for self-administration and explained to the student (Additional forms required) |
|------------|---------|------|------------------|-----------------------|-------------------------------------------------------------------------------------------|
|            |         |      |                  |                       |                                                                                           |

Please describe special side effects, contra-indications, or possible adverse reactions that may occur with any of the above medication on the back of this form. Please attach description of any special procedures this student may need.

Health Care Provider Signature \_\_\_\_\_ Office Phone \_\_\_\_\_

Health Care Provider Print Name \_\_\_\_\_ Date \_\_\_\_\_

I authorize the nurse or delegate to administer the above medications:

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Physician Order and Parent Consent for Epipen**  
**This form is for Epipen Use Only – A copy is to be kept with the Epipen**  
**Epipen Emergency Health Care Plan for Field Trips**  
Contact the School Nurse for a copy if one is already on file in the health office.

Place Child's Picture Here  
Please sign parental consent  
next to the picture in the  
space provided.

Parents/Guardian Signature \_\_\_\_\_

Student's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Allergy to: \_\_\_\_\_

Asthmatic: Yes \_\_\_\_\_ No \_\_\_\_\_ Special Considerations: \_\_\_\_\_

**Signs of Allergic Reaction Include:**

**Systems:** The severity of systems can quickly change. All of the systems below can potentially progress to a life-threatening situation.

**Mouth:** itching and swelling of the lips, tongue or mouth  
**Throat:** itching and/or a sense of tightness in the throat, hoarseness and hacking cough  
**Skin:** hives, itchy rash and/or swelling about the face or extremities  
**G. I. Tract:** nausea, abdominal cramps, vomiting, and/or diarrhea  
**Lung:** shortness of breath, repetitive coughing, and/or wheezing  
**Heart:** "thready" pulse, "passing out"

**Physician Order and Parent Instructions**

1. For signs of a life threatening allergic reaction,  
Give \_\_\_\_\_  
Immediately, followed by \_\_\_\_\_ if needed.

**\*Ordering Physician's Signature\***

**Date**

**Telephone Number**

2. Call Rescue Squad 911 (Request epinephrine) if Epipen or systems not responding.

3. Call (1<sup>st</sup>) Parent \_\_\_\_\_ Tel #/Cell # \_\_\_\_\_

4. Call (2<sup>nd</sup>) Parent \_\_\_\_\_ Tel #/Cell # \_\_\_\_\_

5. Emergency Contact Call

6. Contact #1 Name \_\_\_\_\_ Tel#/Cell# \_\_\_\_\_

7. Contact #2 Name \_\_\_\_\_ Tel#/Cell# \_\_\_\_\_

I consent to have the school nurse/designee administer the medication as prescribed above.

Parent/Guardian Signature \_\_\_\_\_

I plan to have my child carry 2 Epipens at all times. Parent/Guardian Signature \_\_\_\_\_

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**PERMISSION/RESPONSIBILITY FOR STUDENT TO SELF-ADMINISTER  
MEDICATION AS INSTRUCTED. PRESCRIBED AND APPROVED BY  
PRESCRIBER FOR SELF-ADMINISTRATION.**

**(Required only for students self-administering medication)**

**TO BE COMPLETED BY PARENT/GUARDIAN, STUDENT, AND SCHOOL NURSE**

**Name of Student** \_\_\_\_\_

**Name of Parent/Guardian:** \_\_\_\_\_

**Contact Phone Numbers:** \_\_\_\_\_

I have consulted with the health care provider and hereby consent to my child retaining possession of and self-administering the approved medication as indicated on the physician order form. I understand, and have informed my child, that any illegal use of the medication by the student (including the use of the medicine inconsistent with the prescription or sharing the medication with another) will result in disciplinary action.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**TO BE COMPLETED BY STUDENT:**

I understand that I am required to retain possession and self-administer my prescribed medication as outlined by my health care provider, parent/guardian, and trip or school nurse. I have been advised of my responsibility to use my medication only in strict accordance with the prescription. I understand that any use of my medication inconsistent with the terms of my prescription is an illegal use as is the sharing of my medication with another person. I agree to carry a pharmacy labeled container of the medication, to keep a record of the times I use my medication and to share the information with the nurse/instructor/coach who will help evaluate and monitor the effect of my medication.

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

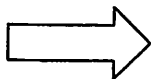
The student has correctly state the 5 rights of medication administration and plan for documentation. The student has correctly stated responsibility regarding the medication.

**School Nurse/Trip Nurse Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

To be filled out for overnight or out of state trips.

**Medications administered by the Trip Nurse or Designated Adult must be recorded and, at the conclusion of the trip, filed in the school health record.**

**SEE ATTACHED MEDICATION ORDER COMPLETED BY PHYSICIAN AND PARENT**  
(Inhalers, epi-pens, diabetic supplies, and any medication needed on an immediate basis are to be kept with the student or with their direct chaperone at all times.)

[illegible]

Copy This Sheet For Each Student That Will Be Receiving Medication

To be filled out for overnight or out of state trips.



Self-administration indicates the student is able to consume or apply medication in the manner directed by the licensed health care provider without additional assistance or direction. The student must meet with the school nurse, trip nurse or delegate to ensure safe self-administration prior to the trip and to develop a medication administration, storage, and handling plan. Inhalers, epi-pens, diabetic supplies, and any medication needed on an immediate basis are to be kept with the student or with their direct chaperone at all times.

**Trip Dates:** \_\_\_\_\_

[illegible]

**Make additional copies as needed.**

## TRIP MEDICAL PAPERWORK CHECKLIST FOR PARENT/GUARDIAN AND STUDENT

Each listed item must be completed. Items underlined are for parent/guardian signature and those in italics for the Primary Care Provider. The medication requirements are based on state mandated regulations.

- \_\_\_\_\_ Insurance information and copy of card – Front and back
- \_\_\_\_\_ Copy of immunization record
- \_\_\_\_\_ Permission and release form signed by parent
- \_\_\_\_\_ Code of conduct signed by student
- \_\_\_\_\_ Code of conduct signed by parent
- \_\_\_\_\_ Emergency contact, medical information and consent for care completed and signed by parent (or student if 18 years of age or older)
- \_\_\_\_\_ *Copy of recent physical with approval for all activity OR the health care provider statement signed by **health care provider** and*
- \_\_\_\_\_ *Medication prescriptions written by **health care provider** for any medication including over the counter medication **essential** for the trip.*
- \_\_\_\_\_ *Self administration approval signed by **health care provider** and*
- \_\_\_\_\_ Self administration approval signed by parent (or student if 18 or older)
- \_\_\_\_\_ *IF carrying an epipen completion of Epipen Emergency health care plan signed by **health care provider** and*
- \_\_\_\_\_ IF carrying an epipen completion of Epipen Emergency health care plan signed by parent (or the student if 18 or older)

Permission for self-administration form signed by 3 people, if the physician approved medication for self-administration.

- \_\_\_\_\_ parent
- \_\_\_\_\_ student
- \_\_\_\_\_ school nurse