Minneapolis Public Schools
Health Related Services

Overnight Field Trip Student Health Information Form

Field Trip/Destination:_____ Date(s) of trip:_____

Dear Parent/Guardian: *Please complete the following health information form and sign below. This information will help field trip staff be aware of the health concerns & needs of participating students.*

Student Name:_____ Teacher/Grade:_____

Address:_____

Parent/Guardian:_____ Phone #:_____ Cell #:_____

Alternate Emergency Contact:_____ Phone #:_____

Insurance Company:_____ Policy #:_____

Health History Information: *Please check all that apply.*

❑ ***No Health Concerns***

❑ ADHD/ADD

❑ Allergies (to what?):_____

❑ Asthma

❑ Bladder/Bowel Problems (Describe):_____

❑ Diabetes, Type: _____

❑ Exposure to drugs and/or alcohol before birth

❑ Heart Problems

❑ Is the student pregnant? Due date: _____ Does the student have children?_____

❑ Seizures, Type: _____

❑ Sleep Concerns (Nightmares, Sleepwalks, etc.):_____

❑ Social/emotional/behavioral/mental health concerns (Describe):_____

❑ Activity Restrictions (Describe):_____

❑ Recent exposure to communicable diseases (If yes, explain):_____

❑ Recent surgeries or hospitalizations (If yes, explain):_____

Date of Student's last tetanus shot:_____

Please describe any other special medical conditions, information or directions:_____

_____

Is your Student currently taking any medication? ❑ Yes ❑ No If yes, Specify Medication(s):_____

_____

The Licensed School Nurse will NOT be available outside of school hours. All questions regarding medications and/or treatments occurring outside of school hours will be directed to the parent/guardian. No on-site or off-site nursing supervision will be provided for this event and parent(s)/guardian(s) will need to be available for calls and emergencies. **911 or emergency medical services will be called in the event of a medical emergency and the student will be transferred to the nearest medical facility**

If your child requires <u>ANY MEDICATION</u> on the field trip, the backside of this form must be completed and returned with the parent/guardian and physician signatures.

The above named student has my consent to take the field trip as described. This health information may be shared with MPS School Staff as needed.

Parent/Guardian Signature:_____Date:_____

Please Turn Over and Complete Back Side for Medications ➔

Date:

Entered in Disc. _____

Scanned to WebNow _____

MINNEAPOLIS PUBLIC SCHOOLS
Urban Education. Global Citizens.

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Authorization for Administration of Medication at School

Parents/guardians asking school staff to give medications to their child must provide (written) permission every school year that has been signed by parent/guardian **and** the child's health care provider.

Student: _____ BD: _____ ID#: _____

School: _____ School year: _____ Grade/Rm: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Physician/licensed prescriber's order for Administration of Medication by School Personnel

***** *Medical Diagnosis & ICD-10-CM Code **MUST** be completed by Physician/Licensed Prescriber* *****

Medical Diagnosis	ICD-10-CM Code	Medication	Dose	Time	Route	Possible Side Effects
1.						
2.						

Other considerations/directions: _____

Start date: _____ Stop date: _____

(All authorizations expire at the end of the school year or following the summer school session.)

_____ _____ _____
Signature of Physician/Licensed Prescriber | Print name of Physician/Licensed Prescriber | Date

_____ _____ _____
Clinic address | Phone | Fax

TO BE COMPLETED BY PARENT/GUARDIAN

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I will notify the school of any change in the medication(s), (i.e., dosage change, medication is stopped, etc.).
3. I give permission for the medication(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.
4. Legally, I may refuse to sign for the medication. If I refuse to sign, we will not be able to administer the medication at school.
5. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

NOTE: Medication must be supplied in original/prescription bottle.

Permission for Release of Information

6. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the action of the medication(s).
7. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by medication(s).
8. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

_____ _____ _____
Parent/Guardian Signature | Date | Relationship to Student

Return to: _____ Phone: _____ Fax: _____
RN, Licensed School Nurse