



Overnight Field Trip

Student Health History Information, Medication Administration and Medical Treatment Authorization Form

Student's Full Name: _____

Birth Date: _____ Age: _____ Student ID Number: _____

Campus: _____ Teacher: _____

Destination: _____ Dates of Trip: _____

Parent/Guardian Name (Please Print Clearly): _____

Relationship to Student: _____

Student's Home Address: _____

Street & Number

City, State Zip

Parent/Guardian Contact Information (Primary):	Secondary/Alternate Guardian Contact Information:
Name:	Name:
Relationship to Student:	Relationship to Student:
Home Telephone:	Home Telephone:
Work Telephone:	Work Telephone:
Mobile Telephone:	Mobile Telephone:
Email:	Email:
Emergency Contact Information:	Physician Contact Information (Primary):
Name:	Name:
Relationship to Student:	Name of Practice:
Home Telephone:	Telephone:
Work Telephone:	Fax:
Mobile Telephone:	Email:
Email:	

Student's Full Name: _____

STUDENT HEALTH HISTORY / INFORMATION:

Health History Awareness: (Please check all that apply & provide comments as appropriate):

Asthma

Diabetes

Heart Defect/Disease Musculoskeletal Disorder

Epilepsy/Seizure Disorder Incontinence/Bed Wetting

Psychological Disorder

Recent Surgeries, Serious Injuries, and/or Hospitalizations

Bleeding/Clotting Disorder

Hypertension

Other Health Condition (Please Specify Below):

Parent/Guardian Comments:

Allergy Awareness: (Please check all that apply & provide comments as appropriate):

Hay Fever

Poison Ivy, Oak, Etc.

Insect Stings

Latex

Food

Known Drug/Medication Allergies (Please Specify Below)

Other Allergy

(If applicable) Are any of the above indicated allergies Life Threatening?

Please Circle One: YES / NO

(If Yes, Allergy action plan(s) as appropriate must be on file with the campus nurse.)

Parent/Guardian Comments:

Any

medically prescribed meal plan or dietary restrictions:

(Physician orders must be on file with the campus nurse.)

Student's Full Name: _____

MEDICATION ADMINISTRATION REQUEST:

	Please initial this box if your child will NOT require prescription medications to be administered while at camp. (Proceed to next section)
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List any prescription medications below that your child will be taking during the trip with instructions. (Additional pages may be attached as needed.)

Prescription Medication Name:	Dose:	Time(s) To Be Given:
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Note: All prescription medications must be in their original container (smallest container available) with the appropriate pharmacy label including doctor's instructions for administration. Place all compliant containers in a Ziploc-style plastic bag labeled with your child's first and last name. Please provide this to your campus nurse at least two days prior to your scheduled departure date. No expired medications will be accepted or dispensed.

	Please initial this box if your child will NOT require non-prescription (OTC) medications to be administered while at camp. (Proceed to next section)
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List any non-prescription medication(s) your child will be taking during the trip with instructions:

Non-Prescription Medication Name:	Dose:	Time(s) To Be Given:
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Note: District-approved non-prescription over the counter medications (Only: Tylenol, Advil, Benadryl, Tums, Cough Drops, Throat Strips, including their generic equivalents) must be age-appropriate and in their original container (smallest container available) with the appropriate label. Designated staff members may administer up to ten doses of district-approved non-prescription medications without a doctor's note. If more than ten doses of a district-approved non-prescription medication is necessary, a doctor's note is required.

Student's Full Name: _____

MEDICATION ADMINISTRATION AUTHORIZATION:

PARENT CONSENT:

- I hereby grant permission for my son/daughter to receive the above medications while on the field trip, as ordered, and authorize school personnel to contact my child's physician if necessary.
- I agree to provide the school with the medication in its original, properly labeled container.
- I understand that during the trip, a designated staff person will carry and administer my child's medication as ordered.

Parent/guardian signature

Date

MEDICATION AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION ONLY:

I, the parent/guardian of _____ request that he/she be allowed to self-administer their inhaler and/or epinephrine auto-injector. My child and I have discussed, and agree that my child will promptly alert CISD staff regarding symptoms and treatment so that appropriate follow-up care can be provided. I understand that the school administration will designate trained staff to monitor the procedure (as made aware of signs/symptoms by the student). It is my understanding that in performing this procedure my child will be using the standardized procedure per the manufacturer directions that has been approved by the physician. My child will keep the emergency medication in his/her: ☐ Backpack ☐ Purse ☐ Other: _____ while on the trip.

PARENT CONSENT:

I agree to the statements above and give permission for my child to carry and self-administer the following medication(s) on this trip for diagnosed life-threatening allergies:

(please choose one or both):

- ☐ inhaler (e.g., albuterol)
☐ emergency epinephrine (e.g., EpiPen)

Parent/guardian signature

Date

Student's Full Name: _____

Special Note Regarding Illness:

- If your child becomes sick while away, you will need to drive to the location of the field trip to pick them up as soon as possible. Exceptions will be made for out-of-state and other trips that are not within driving distance.
- If there is a medical emergency, students will be transported to the nearest hospital.

We appreciate all parents/guardians adhering to these guidelines in order to prevent the spread of illnesses and to support the health and safety of all students and staff. We realize that it may be terribly disappointing for students not to attend this event, but we appreciate your support in our attempts to prevent the spread of illnesses to others and to support the recovery process of the sick child.

PARENT/GUARDIAN GENERAL HEALTH CONSENT AND RELEASE:

- I, the undersigned parent, agree to release, indemnify and hold harmless Celina Independent School District, the Celina School Committee and their employees and agents from and against any claim either I or my child may have as a result of any act or omission which may arise out of this authorization.
- I further consent to urgent medical treatment by a health care provider in the event of illness or injury of our child during his/her participation in the trip/activity/program.
- I accept full responsibility for all costs for any medical treatment.
- I consent for the release of confidential medical information to be released to and from medical providers, the faculty of Celina Independent School District, and the school trip/activity/program chaperones, as needed to maintain my child's health and safety.

Parent/guardian signature

Date

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