Edina Public Schools Overnight Field Trip Authorization and Personal Health History Form

To be completed by parent/guardian for all students attending the overnight field trip

Student's Name _____ Date of Birth_____ Teacher_____

EMERGENCY CONTACT INFORMATION
Parent Contact Info: Home: _____

Parent #1 Name_____ Cell Phone_____

Parent #2 Name _____ Cell Phone_____

Email #l: _____ Email #2: _____

Physician's Name_____Phone_____

Health Insurance Carrier _____ Policy/Group Number: _____

Secondary Contact Info (If parents cannot be contacted):

Name/Relationship _____ Phone _____

Allergies (Check all that apply)

- ☐ Food Intolerance (list & describe reaction) _____
- ☐ Food (list & describe reaction) _____
- ☐ Medication (list & describe reaction) _____
- ☐ Bee Stings (list & describe reaction) _____
- ☐ Seasonal (list & describe reaction) _____
- ☐ Other explain: _____

Does student have a history of: (Check all that apply)

☐ Asthma	☐ Fainting	☐ Wears glasses
☐ Bedwetting	☐ Heart defect/disease	☐ Wears contacts
☐ Bleeding disorder	☐ Menstrual cramps	☐ Hearing impairment
☐ Constipation	☐ Musculoskeletal disorder	☐ Other:_____
☐ Diabetes	☐ Seizures	_____
☐ Emotional/psychological condition	☐ Sleep disturbance	_____

Explain health conditions checked above: _____

_____

_____

Does student have any physical limitations? _____ If yes, please explain: _____

Does student have any diet restrictions? _____ If yes, please explain**: _____**

Medication:

_____ No, my student **does not** need any medication during the field trip.

_____ YES, my student will need medication, but a parent will be **chaperoning** and will manage student medications. (You do not need to complete 2nd page of this form; you will not need to turn in any medication to the health office.)

_____ Yes, my student **will need** medication on the field trip. In order to administer medication (prescription and over-the-counter) on the field trip, parents must **complete page 2** of this form which includes parent signature and written physician's order.

*******This completed form must be returned to school ***as soon as possible*** with parent signature and physician signatures (if required).

In the event of a medical emergency, 911/Emergency Medical Services will be called and student will be transferred to the nearest medical facility.

I understand the arrangements and believe that the necessary precautions and plans for the care and supervision of the children during the field trip will be taken. Beyond this we will not hold the school or those supervising the trip responsible. I give consent for my child to go on this trip.

_____ _____

Parent/Guardian Signature Date **(Over)**

Complete page 2 ONLY if you student required medication on the trip and staff will need to administer.

MEDICATION AUTHORIZATION FOR OVERNIGHT FIELD TRIPS

- **ANY prescription** or **over-the-counter medication** sent on the field trip must include:

  1) The original container. If medication is a prescription, the pharmacy label must accurately reflect medication, dose and times as stated in the orders from doctor
  2) A written order from the physician (if not already on file at the school)
  3) Written parent permission (below)

- Parent / Guardian is responsible for delivering the medication to the health office **5 school days prior** to departure.

- Send only the amount needed for the field trip.

- If it is necessary for medication from school to be sent on the field trip, the parent must contact Health Services Staff in advance to make arrangements. We discourage medications from the school to be sent on overnight fieldtrips.

- Health Services staff do not routinely accompany students on field trips. Teachers will be responsible for administration of medication.

Name of student_____ **Date of Birth**_____

*__Suggested times since schedule variable:__ before meal, after meal, with meal, before bed, at bedtime, etc.

Name of medication _____Dosage_____ Time_____

Name of medication _____Dosage_____ Time_____

Name of medication _____Dosage_____ Time _____

Name of medication _____Dosage_____ Time _____

Name of medication _____Dosage_____ Time _____

Name of medication _____Dosage_____ Time _____

_____ _____ _____

Physician Name (printed) Physician Signature Date

_____ _____

Parent Signature Date