

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

This information and consent form apply to the following field trip:

Destination _____ Teacher/Team _____ Date of trip _____

Name of Student _____ Home Phone _____

Mother _____ Work phone _____ Cell/pager _____

Father _____ Work phone _____ Cell/pager _____

Other emergency contact: _____ Home phone _____ Work phone _____

Allergies (Check all that apply)

- 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 and add an explanation.)

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart defect/disease |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Menstrual cramps |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Musculoskeletal disorder |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Emotional or psychological condition | <input type="checkbox"/> Wears glasses |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Wears contacts |
| <input type="checkbox"/> Other health condition(s) or physical handicap: | <input type="checkbox"/> Hearing impairment |

Explain health conditions checked above.

Does student have any physical limitations or sports restrictions? _____ If yes, Please explain: _____

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

Does your child require medication for the overnight trip? ____ If yes, complete back side.

Medication at camp: In order to administer medication (prescription or over-the-counter) at camp or on the field trip, parents must complete the back of this form which includes parent signature and written physician's order. This completed form must be returned to school 5 days prior to departure date with parent and physician signatures. If an inhaler or Epi-pen is ordered, please indicate if student can self-carry.

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 _____

MEDICATION AUTHORIZATION FOR OVERNIGHT FIELD TRIPS

The administration of medication to students on field trips shall be done only when the student has a medical condition that may be adversely affected without medication. This applies to both prescription and non-prescription medication. The school nurse does not usually accompany students on field trips. The student's teacher will be responsible for storing and administering medication on the field trip. Exceptions are made with parent consent for students with inhalers who are responsible to self-carry and administer their inhalers

- **Any prescription or nonprescription medication sent on the field trip must include:**
 - 1) **the original labeled container**
 - 2) **an order from the physician**
 - 3) **written parent permission**

- **Parent / Guardian is responsible for bringing and giving the medication to the teacher before departure. Send only the amount needed for the field trip. If parents want medication from school to be sent on the field trip, contact Health Services Staff in advance to make arrangements.**

- **The following must be completed in order for medication to be administered on an overnight field trip:**

Name of student _____	Self-carry inhaler	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Self-carry Epi-pen	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Name of medication _____	Dosage _____	Time _____		
Name of medication _____	Dosage _____	Time _____		
Name of medication _____	Dosage _____	Time _____		

_____ Parent/Guardian Signature	_____ Date	_____ Physician Signature	_____ Date
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Parents who plan to accompany their child on the Field Trip should complete this form and return it to school, as requested, but do not need a physician signature for medications they plan to administer themselves

Check here if you plan to accompany your child and to be responsible for your child's medical needs on this Field Trip.