West Salem School District Overnight Medical Form For Overnight Field Trip

WEST SALEM SCHOOL DISTRICT
District Nurse Kate Brohmer RN, BSN: 608-451-1185 (call/text)
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Bus # _____ Grade_____ *Graduation Year (REQUIRED)* _____

PRINTED Student's Name (FIRST AND LAST: _____ Date of Birth: _____

In planning for your child's safety when on the overnight field-trip to _____
Location of Trip
on _____(Dates of Trip), **the following health and medication information is required.**

Student Information:

Student's Physician: _____Printed Name_____Physician's Phone:_____

Parent/Guardian #1: _____

Phone Number: _____

Parent/Guardian Work Number _____

Additional Emergency Contact:_____Phone:_____

Health Insurance Company_____ Insurance Numbers_____

My son/daughter has the following health conditions: (For example: Asthma, Migraines, Diabetes, Seizures)

Please Specify: _____

Please list ANY allergies: _____

Other concerns (sleep walking, bladder control): _____

Below are suggested medications your child might need on the trip. **These medications will be available from staff.**
If you would like your child to have <u>other</u> medications, please send a SMALL, ORIGINAL bottle of any medication your child can receive, and list the medication above, or on the back of this form. All medication (prescription and non-prescription) will be checked at "bag check" time.

Check all medications that may be administered to your student.

Acetaminophen (Tylenol or its generic equivalent) *For headache, discomfort, fever* ☐
Loperamide (Imodium or its generic equivalent) *For diarrhea* ☐
Ibuprofen (Advil, Motrin, or its generic equivalent) *For headache, discomfort, fever* ☐
Dimenhydrinate (Dramamine or its generic equivalent) *For motion sickness, nausea, vomiting* ☐
Diphenhydramine (Benadryl or its generic equivalent) *For allergic reaction, rash, sleep* ☐
TUMS (or its generic equivalent) *For upset stomach, heartburn* ☐
Please also mark one of the following:

☐ **<u>I do NOT give permission</u>** for my student to be administered **<u>any</u>** over the counter medication at any time during the field trip, per package instructions, unless I list them in the medication section on page 2.

☐ **<u>I DO GIVE permission</u>** for my student to be administered **<u>any</u> of the above checked** over-the-counter medications as needed during the field trip, knowing that all medications will be administered to my child by a designated chaperone/staff member, per package instructions.

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I give my consent for the above student to participate in the designated field trip. I authorize any duly qualified healthcare staff, licensed physician and/or surgeon to perform any and all medical services that he/she may deem necessary, in the event that such emergency treatment is required. I expect that every effort will be made to contact me as soon as possible.

STUDENT NAME (Printed) _____

Parent/legal guardian signature_____**PRINTED NAME**_____**Date**_____

MEDICATIONS

I authorize school personnel to exchange information verbally or in writing regarding any medication, listed or checked below, with my child's practitioner for the condition for which it is prescribed.

ALL MEDICATION MUST BE IN THEIR ORIGINAL CONTAINERS, CLEARLY MARKED WITH THE STUDENT'S NAME.
A PROVIDER SIGNATURE IS REQUIRED IF ANY OF THE MEDICATIONS LISTED ARE PRESCRIPTIONS

Name of Medication	Dosage/Frequency	Time(s) of Administration	To Be Given By

THIS SECTION IS TO BE COMPLETED IF STUDENT WILL SELF-ADMINISTER MEDICATIONS.
A PROVIDER SIGNATURE IS REQUIRED IF ANY OF THE MEDICATIONS LISTED ARE PRESCRIPTIONS

Parent/Guardian Consent: I give permission for my child to **self-administer** the above named medications **(controlled substance medications MUST be administered by an adult/staff member**) in accordance with the above instructions and guidelines for overnight field trips. I am aware and understand there will be **no adult supervision regarding self-administration of the medications and my child is aware that sharing of any medication for any reason is strictly prohibited.** I release the School District of West Salem and associated personnel from any liability claims as a result of the administration/non-self-administration of the medication(s) as directed above.

_____ _____ _____ _____
Date ***Parent/Guardian's Signature*** ***Printed name*** ***Phone Number (required)***

Student Consent: I understand that I will be responsible for self-administering my own medication in accordance with the above instructions. I am aware that under no circumstances is any medication to be shared with any one.

_____ _____ _____ _____
Date ***Student's Signature*** ***Printed name*** ***Phone Number (required)***

Healthcare Provider Order Section(For Prescription Medications Only): The above medication(s) may be self-administered in accordance with the above instructions.

_____ _____ _____ _____
Date ***Healthcare Provider's Signature*** ***Printed name*** ***Phone Number (required)***

THIS SECTION IS TO BE COMPLETED IF STUDENT WILL HAVE **PRESCRIPTION MEDICATIONS** ADMINISTERED BY DESIGNATED STAFF. **A PROVIDER SIGNATURE IS REQUIRED.**

Parent/Guardian Consent: I authorize that the above named medication(s) may be administered during the activity indicated on the front of this form in accordance with the School District of West Salem Medication Policy. The Healthcare Provider may be contacted if needed. I release the School District of West Salem and associated personnel from any liability claims as a result of the administration/accidental non-administration of the medication(s) as directed.

_____ _____ _____ _____
Date ***Parent/Guardian's Signature*** ***Printed Name*** ***Phone Number***

Healthcare Provider Order (For Prescription Medications Only): The above medication(s) may be administered in accordance with the above instructions.

_____ _____ _____ _____
Date ***Healthcare Provider's Signature*** ***Printed Name*** ***Phone Number***