

**Needham Public Schools Out-of-State/Country Field Trip
Medication Permission and Emergency Information**

PLEASE RETURN THIS FORM TO THE FIELD TRIP COORDINATOR NO LATER THAN _____

EVENT INFORMATION (To be completed by the Field Trip Coordinator (FTC))

Field Trip Coordinator (FTC) _____

Title of Field Trip, Activity, or Program _____

Location of Event: _____

Date/Time Leaving: _____ Date/Time Returning: _____

Means of Transportation: _____

STUDENT INFORMATION

Student Name _____ Date of Birth _____

School: _____

Student Address: _____

Please list all Parent/Guardian phone numbers for work, home, cell:

Emergency Contacts names and numbers:

Physician's Name: _____

Insurance: _____ Policy # _____

- My child will not be taking any medication on this trip (including Tylenol and/or Ibuprofen). Please check here if applicable. **If your child will not be taking medication on the trip, proceed to the Health History Section on page 2 to complete form.**

******Please list all medications that your student will require on the trip and please note that students are not allowed to carry/transport controlled medications on their person. Controlled medications must be provided to the FTC upon departure by the parent/guardian, in a pharmacy labeled bottle and ONLY send enough supply needed on the trip. Any medication that your student is currently taking, or may need to take on the trip, whether prescription or non-prescription, must be listed. This includes all over the counter medications such as Tylenol, Ibuprofen, allergy medications, etc. Both parent and physician must sign consent for all medications (including over the counter medications) to be self-administered, and the student must consult with the school nurse regarding self-administration. ALL medications must be in the original containers, have a pharmacy printout containing any side effects, and must be labeled with the student's name.***

Medication: _____ Dosage: _____ Time to be given _____

Medication: _____ Dosage: _____ Time to be given: _____

Medication: _____ Dosage: _____ Time to be given: _____

Medication: _____ Dosage: _____ Time to be given: _____

Received by:(initials) _____

Consent for self administration: Yes___No_____ Consent to carry medication (Non-controlled): Yes___ No___

Physician Signature:_____ Date:_____

Physician License Number:_____

Ultimately, the school nurse and parent/guardian will decide if the student is capable of self-administering medication on the field trip; the nurse has the final decision concerning self-administration.

HEALTH HISTORY:

Date of last Tetanus shot:_____

Please list any allergies that your student has including food, medication, environmental, insect, etc.

Other important medical information_____

Parent/Guardian Consent and Release

- *I understand that every effort will be made to contact me if a medical emergency should occur. However, if I cannot be contact or, where time is of the essence, I hereby give permission to medical personnel to provide such medical treatment as is deemed necessary. I/We accept full responsibility for all costs and any medical treatment.*

Initials_____

- *I/We, the undersigned parent/guardian, agree to release, indemnify, and hold harmless the Town of Needham, the Needham 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*

Initials_____

- *I/We consent for the release of confidential medical information to be released to and from medical providers, the faculty of Needham Public Schools, and the school field trip/activity program chaperones, as needed to maintain my child's safety*

Initials_____

Parent/Guardian Signature_____ Date:_____

FOR OFFICIAL USE ONLY:

Student's medication orders have been reviewed by the school nurse YES_____ NO_____

Student has an approved Medication Self-Administration Plan on file with the nurse YES___ NO___ N/A_____

The nurse has instructed the student on safe self-administration practices YES_____ NO_____ N/A_____

Nurse Signature_____ Date_____

Field Trip Coordinator Signature_____ Date_____

