NRSD Required Student Health Form – Overnight Field Trip

To be completed by Parent or Guardian - Please return by (date) _____

Trip to _____ **Dates** _____

Participant Name: _____ Date of Birth: _____

Emergency contact: _____ Cell: _____ H: _____ W: _____

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Does the participant have any Health Problems? ___ **Yes** ___ **No**

Please Explain: _____

List allergies: _____ **Epipen? __Yes __No Inhaler? __Yes __No**

Emergency Action Plans for Overnight Field Trips:

Allergic Reaction: Examples of some of the symptoms include: difficulty breathing, shortness of breath, wheezing, difficulty swallowing, hives, itching, swelling of any body part.
Action Plan: **Staff member assists student as needed in using Epipen and calls 911 and parent/guardian. Staff member accompanies student to emergency room.**

Asthma: Student has difficulty breathing, wheezing, and/or shortness of breath.
Action Plan: **Staff member assists student as needed in using his/her inhaler. If no relief of symptoms in five (5) minutes, will call 911 and parent/guardian. Staff member accompanies student to emergency room.**

Diabetes: Low blood sugar reaction- hunger, sweating, pallor, feels shaky, headache.
Action Plan: **Staff member assists student to drink a juice box or regular soda, or eat glucose tablets or a snack from their emergency snack pack. Student will test their blood glucose level and record number. Staff member/student will notify parent/guardian. If no change in symptoms in five (5) minutes, student will repeat all of the above steps. Student will recheck blood glucose in 10 minutes. If student becomes unconscious or seizes, staff member will call 911 and parent/guardian. Staff member will accompany student to emergency room.**

Seizure: Altered consciousness, involuntary muscle stiffness or jerking movements, drooling/foaming at the mouth, temporary halt in breathing, loss of bladder control.
Action Plan: **Staff member will protect student from injury and call 911 and parent/guardian. Staff member accompanies student to emergency room.**

Student-specific instructions: _____

_____

Health Insurance Yes ☐ No ☐ Name and Number of Plan _____

Name of Subscriber _____ Group Name & Number _____

Insurance phone # to contact if prior approval is required _____

Date _____ Parent/Guardian Signature: _____

NRSD Overnight Field Trip: Physician's Medication Order and Parent Consent

The Commonwealth of Massachusetts requires that parents/guardians of all students who need prescription and non-prescription medication during school sponsored functions (field trips) do the following:

1. Present a written medication order signed by the physician.
2. Present a written consent signed by the parent or legal guardian.
   Please also:
3. Send only essential medications on the trip.
4. Provide all medications in the **original** box/container or prescription bottle labeled by a registered pharmacist. (Note: the pharmacy will provide you with a second labeled bottle if you request it)
5. **Please check expiration dates. Expired medications cannot be accepted.**
6. Provide only the number of doses necessary for the duration of the trip.

Medical Release

I, _____, Legal Guardian of _____ grant to NRSD school staff the right to obtain emergency medical or dental treatment for my child _____ during the period of the _____ Trip, including but not limited to (date)___through (date)_____. Payment for any and all medical treatment is the financial responsibility of the parent/guardian. I understand the school nurse may need to share information relative to the prescribed medication (e.g. adverse side effects) with appropriate trip personnel on an as needed basis as she determines necessary for my son's/daughter's health and safety. My child has my permission to self-administer medication when the school nurse deems that it is safe and appropriate. I understand that non-compliance with any request made in regards to medications and/or health and safety will result in my child's exclusion from the overnight trip.

Physician's Order and Consent

Medication name	Diagnosis/indication	Dosage	Times or as needed	Self-Administer?

Other pertinent information regarding this student's health:

_____

PHYSICIAN SIGNATURE: _____ **Phone**_____

PARENT/GUARDIAN SIGNATURE:_____ **Date**_____