MINNEAPOLIS PUBLIC SCHOOLS
Urban Education. Global Citizens.

Minneapolis Public Schools
Health Related Services

Overnight Field Trip Student Health Information Form

Field Trip & Destination: _____

Teacher/Grade Level: _____ Date(s) of trip: _____

Dear Parent/Guardian: Please complete the following health information form. This information will help field trip staff be aware of the health concerns & needs of participating students.

Name of Student: _____ Home Phone: (___)_____

Home Address: _____

Parent/Guardian: _____ Work Phone: (___)_____

Cell Phone: (___)_____

Alternate Emergency Contact: _____Phone: (___)_____

Insurance Company: _____ Policy Number: _____

Health History Information: Please check all that apply:

Asthma ❑	Nightmares ❑	Heart condition ❑
Diabetes ❑	Bed Wetting ❑	Stomach aches ❑
Seizures ❑ Type: _____	Sleepwalks ❑	Ear infections ❑
ADHD ❑	Faints easily ❑	Other: _____

Allergies: _____

Sensitivity to Poison Ivy, Sumac or Oak: _____ Date of last tetanus shot: _____

Is there any reason to limit your child's activity? ❑ Yes ❑ No

If yes, please explain: _____

Has your child been recently exposed to any communicable diseases? ❑ Yes ❑ No

If yes, please explain: _____

Please describe any other special medical conditions, information or directions: _____

_____

Is your child currently taking any medication? ❑ Yes ❑ No

If yes, specify: _____

If your child requires ANY MEDICATION on the field trip, that is not already given at school, <u>the backside of this form must be completed and returned 5 school days prior to the departure date with parent and physician signatures.</u>

***911 or emergency medical services will be called in the event of a medical emergency and the student will be transferred to the nearest medical facility.**

Please Turn Over and Complete Back Side for Medications ➔

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Authorization for Administration of Medication at School

Parents/guardians asking school staff to give medications to their child must provide (written) permission every school year that has been signed by parent/guardian **and** the child's health care provider.

Student: _____ BD: _____ ID#: _____

School: _____ School year: _____ Grade/Rm: _____

Physician/licensed prescriber's order for Administration of Medication by School Personnel

Medical Condition	Medication	Dose	Time	Route	Possible Side Effects
1.					
2.					

Other considerations/directions: _____

Start date: _____ Stop date: _____

(All authorizations expire at the end of the school year or following the summer school session.)

_____ _____ _____
Signature of Physician/Licensed Prescriber | Print name of Physician/Licensed Prescriber | Date

_____ _____ _____
Clinic address | Phone | Fax

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I will notify the school of any change in the medication(s), (i.e., dosage change, medication is stopped, etc.).
3. I give permission for the medication(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.
4. Legally, I may refuse to sign for the medication. If I refuse to sign, we will not be able to administer the medication at school.
5. This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

_____ _____ _____
Parent/Guardian Signature | Date | Relationship to Student

NOTE: Medication must be supplied in original/prescription bottle.

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the action of the medication(s).
2. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

_____ _____ _____
Parent/Guardian Signature | Date | Relationship to Student

Return to: _____ Phone: _____ Fax: _____
RN, Licensed School Nurse