

OVERNIGHT FIELD TRIP MEDICAL FORM

FOR ALL IN-STATE, OUT-OF-STATE, AND INTERNATIONAL TRIPS

Student Emergency Contact and Medical Information

Child's Name (Last, First, Middle)		Date of Birth	M	F
		Gender		
Parent/Guardian Name		Parent/Guardian Name		
Home Phone	Cell Phone	Home Phone	Cell Phone	
Address		Address		
City, State ZIP Code		City, State ZIP Code		

Alternate Emergency Contacts

If parent(s)/guardian(s) are not immediately available.

Primary Emergency Contact		Secondary Emergency Contact	
Relationship to Student		Relationship to Student	
Home Phone	Cell Phone	Home Phone	Cell Phone
Address		Address	
City, State ZIP Code		City, State ZIP Code	

Health Information

Provide detailed information on the following pages as this form will be used should your child require emergency medical care.

Attach to this form:

- 1) **Student's immunization record**
- 2) **Student's health insurance card(s)**

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Does your child have any of the following:
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list all allergies and treatment plan, including medication:
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list treatment plan, including medication:
Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list treatment plan, including medication:
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list treatment plan, including medication:
List all other health issues, including mental health issues, and treatment plan, including medication:
List activity restrictions and/or needed accommodations for your child:

MEDICATION

All prescription medication must be in a pharmacy-labeled container.
 All over-the-counter medication must be in the manufacturer’s container.

SELECT A or B FOR ADMINISTRATION OF MEDICATION

A. Medication to be Administered by Staff

List all medication (prescription and over-the-counter) to be administered by staff

NAME OF MEDICATION	DOSE	TIME TO BE GIVEN	NUMBER OF DOSES PER DAY	POSSIBLE SIDE EFFECTS

Consent and Release – Medication to be Administered by Staff

My child will NOT carry over-the-counter or, prescription medication on this field trip.

I/We, the undersigned parent(s)/guardian(s), give permission to the field trip teacher(s)/chaperone(s) to administer the above medication to my child or to supervise my child in taking the above medication. I agree to release, indemnify and hold harmless the City of Newton, the Newton Public Schools, the Newton 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.

 Parent/Guardian Signature

 Parent/Guardian Name (Please print)

 Date

B. Medication to be Administered by Student (Self-administered)

List all medication (prescription and over-the-counter) to be administered by student
 (Self-administered)

NAME OF MEDICATION	DOSE	TIME TO BE GIVEN	NUMBER OF DOSES PER DAY	POSSIBLE SIDE EFFECTS

Consent and Release Medication to be Administered by Student (Self-administered)

I/We, the undersigned parent(s)/guardian(s) give permission for my child to self-administer the above medication and understand that no Newton Public Schools (NPS) employee will be administering the medication. If my child is residing with a host family without any NPS staff, I understand that NPS will not be supervising my child’s self-administration of medication. I agree to release, indemnify and hold harmless the City of Newton, the Newton 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.

 Parent/Guardian Signature

 Parent/Guardian Name (Please print)

 Date

PERMISSION FOR EMERGENCY TREATMENT CARE

I understand that parents/guardians will be contacted for any serious illness or accident. In the event of a medical emergency, **I, the parent/guardian, hereby give permission for hospitalization and/or proper medical treatment for my child by health care providers selected by the trip leader/host family.**

List of Chaperones/Host Family Members

Parent/Guardian Signature

Parent/Guardian Name (Please print)

Date