



## Burlington Area School District EXTENDED or OVERNIGHT FIELD TRIPS

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**RETURN this form with a copy of Medical Insurance Card to the School Health Office  
at least 7 Days Prior to Field Trip**

**Event Name:** \_\_\_\_\_ **Staff Member/Coach Responsible:** \_\_\_\_\_

**Student Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Primary Phone #:** \_\_\_\_\_

**Parent / Guardian Name(s):** \_\_\_\_\_ **Secondary Phone #:** \_\_\_\_\_

**Emergency Contact / Relationship:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Family Health Care Provider:** \_\_\_\_\_ **Date of Last Tetanus Booster:** \_\_\_\_\_

**Health Conditions:**

- | Yes | No  |   |
|-----|-----|---|
| ___ | ___ | Medication Will be Taken on Trip (If "Yes" - Review guidelines below & complete the back of this form)                                  |
| ___ | ___ | Asthma (be sure to send inhaler along with student)   |
| ___ | ___ | Diabetes (all supplies are to be provided by the parent / guardian)   |
| ___ | ___ | Heart Problems : _____  |
| ___ | ___ | Bone / Joint Disorder: _____  |
| ___ | ___ | Bleeding Disorder: _____  |
| ___ | ___ | Seizure Disorder: _____   |
| ___ | ___ | Migraines - Headache / Abdominal  |
| ___ | ___ | Motion Sickness (bus / airplane / boat)   |
| ___ | ___ | Sleep Walking   |
| ___ | ___ | ADHD / ADD  |
| ___ | ___ | Depression / Anxiety / Mental Health Concerns: _____  |
| ___ | ___ | Allergy: (Be specific in severity, type and reactions seen - <b><i>If Epi-Pen is needed, TWO Pens are required</i></b> )<br>Type: _____ |
| ___ | ___ | Other Health Problems (specify) _____   |

**Medications to be Taken on Trip: (If applicable - complete Medication Consent Form - on Back)**

- Prescription medications must be in the original current prescription bottle with student name, correct dosing & administration instructions on the label. Over-the-counter medications must be in the original unexpired bottle with legible label for dosing safety. (School policy 453.1) Write your child's name on the bottle with permanent marker.
- **Prescription medications require you to submit a doctor's order to the school health office prior to the event.**
- **Only send medication(s) & the number of pills that will be needed for the trip duration**
- **ALL** medications require a Medication Consent Form on file in the Health Office and must be checked into the School Health Office, one day prior to event departure & be picked back up by a parent if any medication remains, post trip.
- All medications will be carried by the staff member responsible for coordinating the trip. With the exception of inhalers, epi-pens, & diabetic medications, **students are not allowed to carry medications with them.**

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**I hereby authorize the teacher or person in charge, to provide 1st Aid / Treatment & understand that EMS will be called for my child, named above, when necessary. I authorize all health information I have provided is current and correct and may be shared with the individuals who have a need to know, for the safety and well-being of my child.**

\_\_\_\_\_  
**Signature of Parent / Guardian REQUIRED**

\_\_\_\_\_  
**Date**

Revised 2/2018



**BURLINGTON**  
AREA SCHOOL DISTRICT

# HEALTH SERVICES DEPARTMENT

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(262)763-0210 (262)763-0215 Fax

## MEDICATION ADMINISTRATION CONSENT FORM

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Allergies: \_\_\_\_\_

### Parent / Guardian Authorization:

I, the parent/guardian of the above named student, have read the school's medication policy & request the medication listed below to be administered to my child at school. I understand that I am responsible for bringing the medication to school in its original, updated, properly labeled container and for picking up any unused medication by the 2nd business day after classes conclude for the current school year (all medications will be disposed of after this time - no medications will be sent home with a student). I understand that a qualified, designated person will be administering the medication & that I am responsible for maintaining a sufficient quantity at school to avoid interruptions with the MD orders. I understand that if my child refuses a prescription drug, force will not be exerted by school personnel to make them comply. I will notify the school immediately if there is a change or cancellation of the medication. The school district has my permission to contact the prescriber in regard to medications that are prescribed.

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
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### ***NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION PORTION: (MD signature NOT required)***

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time: \_\_\_\_\_ Route: \_\_\_\_\_ Reason: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
=====

### ***PRESCRIPTION MEDICATION PORTION ONLY: (To be completed by a MD / PA /NPAP Only)***

Medication & Dosage: \_\_\_\_\_ Amt: \_\_\_\_\_ Time: \_\_\_\_\_

Route: \_\_\_\_\_ Reason: \_\_\_\_\_ Side Effects: \_\_\_\_\_

### EMERGENCY MEDICATION MANAGEMENT (Asthma Inhalers / Epi-Pens / Glucagon) :

Student \_\_\_\_ CAN \_\_\_\_ CANNOT carry & self-administer the prescribed **RESCUE INHALER**

Student \_\_\_\_ CAN \_\_\_\_ CANNOT carry & self-administer the prescribed **EPI-PEN**

Student \_\_\_\_ CAN \_\_\_\_ CANNOT carry the prescribed **GLUCAGON**

Medical Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_