Burlington Area School District
EXTENDED or OVERNIGHT FIELD TRIPS

Jessica M. Polcyn BSN, RN, NCSN ■ Lori Sanchez BSN, RN
Health Service Department, 100 North Kane Street, Burlington, WI 53105
(262) 763-0210 Fax: (262) 763-0215

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 - ***If Epi-Pen is needed, TWO Pens are required***) 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**.

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

Jessica M. Polcyn BSN, RN, NCSN
Lori Sanchez BSN, RN
100 North Kane Street
Burlington, WI 53105
(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**: _____

==========

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: _____