Burris Laboratory School

Overnight Field Trip/Japan Health History, Consent to Treatment

Medication Consent OTC & Prescription, Health info & consents, Dietary concerns

Field Trip:_____

Dates:_____ Sponsor:_____

Student General Information:

Student Name:_____Date:_____

DOB:_____ Address:_____

Parent:_____

Phone:_____ Work Phone:_____

Parent:_____

Phone:_____ Work Phone:_____

Medical Information

Physician:_____ Phone:_____

Date of last Tetnus, Dtap, TD, Tdap:_____

Health Insurance:_____

Policy #_____ Group #_____

You must attach a copy of front and back of current insurance card

List Allergies Food, Medicine, etc:_____

Type of Reactions:_____

Please list any dietary restrictions that are medically needed:_____

_____

Will student bring Epi-pen or Auvi-Q and Benadryl? _____ Yes _____ No

List Medical Diagnosis/Health History:_____

_____

Does your student have any Medical conditions that your or your physician feel would limit physical participation in field trip/camp? _____ Yes _____ No

If yes explain:_____

Is your student currently taking any medication that may interfere with ability to safely participate in field trip/camp? _____ Yes _____ No

If yes explain:_____

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Prescription Medication

I give my permission for my child to participate in the above mentioned school related field/camp. All health information provided by me is correct and accurate to the best of my knowledge. I authorize trained school personnel, volunteer nurses to administer mediations while on field trip/camp. ***Parent initial:_____***

- All medications MUST be in original pharmacy bottles
- Please send only amount of medication needed for field trip/camp
- Only medically necessary prescription medications should be brought
- Labels should be intact on pharmacy bottles with proper medication and students name and dosing instructions
- ONLY emergency medications will be permitted as self carry such as inhalers and epi-pens
- If my student require food as part of a medical treatment, parent is to supply those needs
- All medical supplies for chronic conditions will be supplied by parents
- Controlled medications will be kept with staff/nurse to comply with school policies: students are not permitted to self administer controlled substances

Medications to be completed by physician: Please complete or attach order for all prescription medications that will be needed during school field trip/camp.

Medication:_____ Dose:_____

Frequency/Time:_____ Dose form:_____

Diagnosis for Medication:_____

Medication:_____ Dose:_____

Frequency/Time:_____ Dose form:_____

Diagnosis for Medication:_____

Medication:_____ Dose:_____

Frequency/Time:_____ Dose form:_____

Diagnosis for Medications:_____

For epi-pens and rescue inhalers: Student has been instructed by the physician in the proper uses and may carry inhaler/epi-pen on them. **Physician initial:_____**

Printed Physician Name:_____

Physician Signature:_____ Date:_____

Address:_____ Phone:_____

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Over The Counter Medication

- Only Acetaminophen,/Tylenol, Advil/Ibuprofen, cough drops, Tums, Midol, Tylenol Headache, Advil Migraine will be accepted.
- **No cough syrup, herbal, vitamins, supplement, will be administered unless a physician's order is present.**
- Parents will supply OTC medications except ones provided by school.
- OTC medications will be administered per manufacturers guidelines. Otherwise, a physician's order will need to be presented.
- OTC Zyrtec, Clariten, Allegra will be accepted.
- OTC medications must be in original pharmacy packaging/bottles.
- Labels on bottles must be intact

Medication:_____ Diagnosis:_____

Medications:_____ Diagnosis:_____

Medicaitons:_____Diagnosis:_____

As the Parent of student_____ I understand that the information requested on this form is intended to help in my student's care and safety. In case of an emergency situation this information will help in the quick treatment of my student. Parents are responsible for providing accurate medical history. It is recommended that you consult with your physician prior to this field trip/camp.

- I understand that Ball State University does not provide any health insurance for my student participating on this field trip/camp.
- I give permission for staff involved on this field trip/camp to seek medical care for my student in the event of illness, injury or medical emergency and to release medical information as needed on this form for their health care.
- Efforts will be made to notify parents/guardians prior to seeking care for injury, illness or medical emergency.
- I grant permission for trained staff/volunteer nurses to administer medications and first aid to my student during this trip/camp.
- As the parent/guardian I understand and acknowledge that my failure to disclose relevant medical information may result in harm or delay in care during this field trip/camp.
- I understand that staff and volunteers will exercise precautions to protect students. However, in the event of an accident, I agree to hold harmless Ball State University, Teacher's College, Burris Laboratory School, Ball State university employees and volunteers from any liabilities for said accident.
- Parent is to complete this form completely and bring all medications and chronic disease supplies to clinic two days prior to field trip/camp.
- As the parent/guardian of the above student, I hereby give permission for him/her to attend _____ from Dates:_____

Signature_____ Date_____

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Emergency Contacts:

In case of Emergency, if Parents listed are unable to be reached please list someone authorized as emergency contacts.

Contact:_____ Relationship:_____

Phone:_____ Work:_____

Contact:_____ Relationship:_____

Phone:_____ Work:_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____

Parent Initials:_____Date:_____

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Japan Exchange Program

Consent for Self Administration of Medication

Student's Name:_____ DOB:_____

Parent:_____ Date:_____

Home:_____ Work:_____

For the Japan Exchange program October 2015, I hereby consent to allow my child_____ to self-administer the following medication during the course of the is exchange program. This consent will not apply to any other school related activities or school day.

I, on behalf of myself and my child agree to hold harmless, release Burris Laboratory school, Ball State University, Burris Laboratory School staff and host families for any liability, claim, or cause of any action of any nature whatsoever, including but not limited to personal injury or death as the result of my child's self administration of medication. I have read and understand the guidelines listed below.

I further consent release of this information pertaining to medication be disclosed with pertinent staff, host families involved in the exchange program.

Student guidelines for self-administration of medication:

1. Student medications must be in original bottle from pharmacy and label intact.
2. Student has been instructed on proper administration and is responsible for medication.
3. Student use/administration of medication will not be monitored by Burris Laboratory School staff/host families.
4. Student must not share or give any OTC/prescription medication with any other student/person.
5. Student/parents must follow TSA guidelines for traveling with medications
6. Only carry the amount of prescription medication that is needed for the duration of the trip.

Parent printed Name:_____ Date:_____

Parent Signature:_____

Physician Statement supporting self-administration of prescription medication:

Name of medication:_____

Method of self-administration:_____

Dosage:_____ Time of scheduled administration:_____

Side effects or special instructions:_____

_____

I confirm that this student is able to self-administer this medication according to the guidelines listed above

Physician printed Name:_____ Date:_____

Physician Signature:_____ Phone:_____