Burris Laboratory School

Overnight Field Trip Health History, Consent for Treatment & Medication

Field Trip: _____

Dates: _____ Teacher: _____

Student General Information

Student Name: _____ DOB: _____

Student Address: _____ City: _____ State: ____ Zip: _____

Parent: _____ Work Phone: _____ Cell: _____

Parent: _____ Work Phone: _____ Cell: _____

Medical Information

Physician Name: _____ Physician Phone: _____

Date of last Tetanus, Dtap, TD: _____

Health Insurance: _____

Policy #: _____

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD

Allergies – Food & Medication: _____

Type of Reaction: _____

Is Epi-Pen, Avui-Q or Benadryl required for allergies? _____ Yes _____ No

List Medical Diagnosis and Health History: _____

_____

Does your student have any medical conditions that you or your physician feel would limit physical participation in this field trip? _____ Yes _____ No

If yes please explain: _____

_____

As the parent/guardian of _____ 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/guardians are responsible for providing accurate medical history.

- I understand that Ball State University does not provide any health insurance for my student participating in this field trip.
- I give permission for staff involved on this field trip 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 care.

- Efforts will be made to notify parents/guardians prior to seeking care for injury, illness or medical emergency.
- I grant permission for staff to administer medications and first aid to my student during this field trip.
- As the parent/guardian I understand and acknowledge that my failure to disclose relevant medical information may result in harm or delay in care of my student.
- 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 employees and volunteers from any liabilities for said accident.
- Parent/guardian is to complete this form completely and supply all medications to the clinic 3 days prior to travel, _____ (date).
- Please return this form no later than: _____ (date).
- Please do not send any medication with your child to carry on the trip.
- As the parent/guardian of student, I hereby give my permission for my student to attend this field trip.

Parent Signature: _____ Date: _____

Prescription Medication

Medication	Dose	Time	Special Instructions

- Please only send the number of pills needed for this trip.
- All medications, whether over-the-counter or prescription must be in the original container with the student's name and dosage information clearly labeled.
- If the medication is an emergency medication that the student self-carries and/or self-administers please have the bottom of this page signed by your physician.

Printed Physician name: _____
Physician Signature: _____ Date: _____
Phone number: _____

Over-The-Counter Medications

Burris Laboratory School will provide Acetaminophen (generic for Tylenol), Ibuprofen, and Diphenhydramine (generic for Benadryl) for student use while on the field trip. Please check any or all of the following over-the-counter medications that staff have parental/guardian permission to administer if necessary:

Acetaminophen: _____ Yes _____ No
Ibuprofen: _____ Yes _____ No
Diphenhydramine:_____ Yes _____ No

Parent Signature: _____ Date: _____

This part must be completed if your student has not completed any portion of the prescription medication, OTC medications.

My student_____, requires no routine medication to be given during camp. I have also reviewed the listed over the counter medications which are available during the field trip and I do not want my student to receive any of these medications.

Date:_____ Signature:_____

Dietary Concerns

Please list any medically necessary dietary restrictions/concerns: _____

_____

_____

_____

Restrictions are due to what diagnosis: _____
Please list any other special dietary concerns such as vegan or vegetarian diets: _____

_____

_____

_____

Emergency Contacts

In case of Emergency, if parents/guardians 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: _____