RMAE OVERNIGHT TRIPS - MEDICAL INFORMATION

Student's Name ____ Height______ Weight ______

Last First Middle Male ______ Female ______

Birthdate: ___________________________ Age: _____

MM/DD/YYYY

Child Resides With: Both Parents _______Father ____Mother ____Shared households____Other (specify) : __________

Complete Address ____

Number Street Apt # City Zip

Father's Name ______________________________ Mother's Name ______________________________

Father's Home/Cell Phone ______________________ Mother's Home/Cell Phone ______________________

Father's Work Phone __________________________ Mother's Work Phone __________________________

Father's Email _______________________________ Mother's Email _______________________________

Emergency Contact Name (in case neither parent can be reached):______________________________

Telephone: ______________________________ Relationship: ______________________________

Name of Child's Physician ____

Address ____

Physician's Phone: Day: ______________________ Night: _________________________________

Preferred hospital in case of emergency ____

Please list any and all medications, vitamins, herbs, homeopathic or essential oils that you expect to send with your child:

______________________________________ ______________________________________

Name of drug – Reason taking Name of drug – Reason taking

______________________________________ ______________________________________

Name of drug – Reason taking Name of drug – Reason taking

______________________________________ ______________________________________

Name of drug – Reason taking Name of drug – Reason taking

An additional medication form, which must accompany the medication, is attached within.

PERMISSION FOR ADMINISTRATION OF MEDICATION AND EMERGENCY CARE

I hereby request and give my permission to the Jefferson County School District R-1 to administer medication to the student identified above. I understand that it is my responsibility to provide ALL medications. I understand that all medication must be provided in the original pharmacy labeled containers. I understand that my child assumes responsibility for going to the staff chaperone at the specified time(s) for medications. I acknowledge that the administration of this medication by school personnel is an accommodation performed solely upon my request. In consideration of the acceptance of this request, I release and waive any and all claims which I now have or may hereafter have against the Jefferson County School District R-1 and its employees arising out of the administration of or failure to administer the medication to the student or any adverse reaction by the student to the medication.

I understand that if my child requires medical attention, the RMAER staff will attempt to contact me first. If I am unavailable, my child's physician, listed above, will be called. Should I or my physician be unavailable, I hereby authorize any emergency medical treatment that is deemed necessary, or any medical treatment I specifically authorize in advance. I also give permission for school personnel to transport my child or arrange transportation, in an emergency or if medical care is needed.

____ ___ ____________________

* **Required** Signature of Parent or Legal Guardian Date

STUDENT'S NAME: ____
Last First Middle

I. Please list any medical condition/concerns, recent injury or hospitalization: ______________________________________
____
____

II. Please list any activity restrictions/limitations or any assistive device (ie. prosthetic, hearing aid, etc) that will be sent:
____

III. Does your child have asthma? Yes ___ No ___ Please explain: trigger/frequency/severity/treatment of attacks :
____

Do you feel your child needs to carry their rescue inhaler with them at all times while attending the trip?
Yes:____No:____
Do you feel your child is responsible enough to carry his/her rescue inhaler while on the trip ? Yes ___ No___ N/A __

IV. Known allergies: Hayfever ___Bees ____ Food (name food)_________________Drug Allergy (name of drug): ___________
Other: _______________
Explain reaction: ____
If your child has an Epi Pen, has it ever been used: No:_____ Yes:______ If yes, when:_____________________________
V. Does your child need a special diet? ________ If yes, explain:____
____

VI. Circle any condition needing bottom bunk: Bedwetting____ Frequent urination ____Sleepwalking____ Seizures_____
Restlessness____Other____ Further explanation: ____
VII. Any separation or homesickness issues? If yes, explain: ____
Attach an additional sheet of paper if there is any other information you wish to share relating to your child's well-being.

ACCIDENT INSURANCE COVERAGE INFORMATION

An insurance policy covering accidental injuries to students while on overnight trips is provided as part of the student's tuition fee. The policy provides a limited amount of coverage for all or part of the cost of the treatment of accidental injuries, depending on the nature and extent of the injury. Parents are responsible for those portions of medical bills not paid by the insurance company.

PARENTS/GUARDIANS ARE RESPONSIBLE FOR ANY MEDICAL EXPENSES, INCLUDING EMERGENCY EVACUATION, SHOULD THEIR CHILD SUSTAIN A NON-ACCIDENT RELATED ILLNESS ON ANY OVERNIGHT TRIPS.

____
* REQUIRED SIGNATURE OF PARENT OR GUARDIAN

IF YOU HAVE A RELIGIOUS/PERSONAL OBJECTION

Because of religious convictions or personal objections, my child or ward is to receive NO BLOOD OR BLOOD PRODUCTS (please circle if applicable) or NO MEDICATION in any form (please circle if applicable). I do understand that in the event of life-death situation my child or ward, regardless of religious or personal convictions, will be administered life-sustaining first aid and medical care.

____ ____________________________________
Signature of Parent or Legal Guardian if Applicable Date
Please sign here ONLY if you have a RELIGIOUS or PERSONAL objection.

Extended Field Trip Medication Form- Middle School (Grades 6-8)

Purpose: This form must be completed for every student taking any medication on an extended field trip outside of the regular school day. Medication includes prescription, over the counter, herbal/homeopathic, and (non)essential oils. Please see Jeffco BOE Policy Administering Medicines to Students for more information.

- This form must be returned to the Field Trip Coordinator **4** weeks prior to departure allowing for necessary review and planning.
- All medications must be checked in to the Field Trip Coordinator 1-2 days prior to departure.
- Please review the parent checklist to make sure all information is complete.
- If your school is providing any over the counter medications, they must be listed below. Please ask your Field Trip Coordinator for the list of provided medications.

This form must be completed by a Medical Provider and signed by a parent/legal guardian. A Medical Provider must have prescriptive authority in the state of Colorado.

STUDENT NAME: ____ DOB:__________________
Health Concerns: ____Age:_____
Allergies: ____

I approve administration of the above medications as indicated. I understand if an Individualized Student Health Plan (ISHP) is required for a known health condition, it is my responsibility to notify the district RN and the school administration **8** weeks prior to departure. A school meeting to discuss health planning/ accommodations may be required.
Parent signature: ____ Date:_________
Medical Provider signature: _____________________________ Date:_________

District RN review:______________________________________ Date: ___________

Sunscreen, lip balm, and insect repellent are to be provided by the parent but do not require a Medical Provider signature. I give my permission for my child to apply these items while on the trip.
Parent Signature: _______________________________

Please provide the following information for each medication to be administered on the trip:
Medication #1: ____
CHECK ONE: As needed ____ Daily ____
TIMES TO BE GIVEN: ______________________________AM/PM
REASON FOR GIVING: ____
Special Instructions: ____
My child can responsibly carry and self-administer this medication yes no

Medication #2: ____
CHECK ONE: As needed ____Daily ____
TIMES TO BE GIVEN: ______________________________AM/PM
REASON FOR GIVING: ________________________
Special instructions: ____
My child can responsibly carry and self-administer this medication yes no

Medication #3: ____
CHECK ONE: As needed ____ Daily ____
TIMES TO BE GIVEN: ______________________________AM/PM
REASON FOR GIVING: ____
Special Instructions: ____
My child can responsibly carry and self-administer this medication yes no

Medication #4: ____
CHECK ONE: As needed ____ Daily ____
TIMES TO BE GIVEN: ______________________________AM/PM
REASON FOR GIVING: ____
Special Instructions: ____
My child can responsibly carry and self-administer this medication yes no

Medication #5: ____
CHECK ONE: As needed ____ Daily ____
TIMES TO BE GIVEN: ______________________________AM/PM
REASON FOR GIVING: ____
Special Instructions: ____
My child can responsibly carry and self-administer this medication yes no

Medication #6: ____
CHECK ONE: As needed ____ Daily ____
TIMES TO BE GIVEN: ______________________________AM/PM
REASON FOR GIVING: ____
Special Instructions: ____
My child can responsibly carry and self-administer this medication yes no

Medication #7: ____
CHECK ONE: As needed ____Daily ____
TIMES TO BE GIVEN: ______________________________AM/PM
REASON FOR GIVING: ________________________
Special instructions: ____

Medication #8: ____
CHECK ONE: As needed ____ Daily ____
TIMES TO BE GIVEN: ______________________________AM/PM
REASON FOR GIVING: ____
Special Instructions: ____
My child can responsibly carry and self-administer this medication yes no