**WEST SALEM SCHOOL DISTRICT**
**MEDICAL FORM FOR OVERNIGHT FIELD TRIPS**

Kate Brohmer RN, BSN District Nurse
WSHS Office (608) 786-1220 | WSHS Fax (608) 786-1273 | Nurse Cell: 608-451-1185 | brohmer.kate@wsalem.k12.wi.us

# West Salem School District Overnight Field Trip Form

**Bus # _____ Grade_____ Graduation Year _____ (required)**

Student's Name: _____Date of Birth: _____

**In planning for your child's safety when on the overnight field-trip to _____**
Location of Trip

on _____, the following health and medication information is needed.
Date of Trip

**Student Information:**

Student's Physician: _____Physician's Phone: _____

Parent or Guardian: _____ Phone: _____

Mom Work Number _____Dad Work Number _____

Additional Emergency Contact:_____Phone:_____

Health Insurance Company_____ Insurance Numbers_____

My son/daughter has the following health conditions: (For example: Asthma, Migraines, Diabetes, Seizures)

Please Specify: _____

Please list any allergies: _____

Other concerns (sleep walking, enuresis): _____

Below are suggested medications your child might need on the trip. **These meds will be provided**. If you would like your child to have <u>other</u> medications, please send a SMALL bottle of any medication your child can receive, and list the medication on the back of this form. If there is any medication you do not want your child to receive please cross it off the list below. All medication (prescription and non-prescription) must be turned in to the Nurse at your student's school prior to departure.

Acetaminophen (Tylenol or its equivalent) *For headache, discomfort, fever*
Loperamide (Imodium or its equivalent) *For diarrhea*
Ibuprofen (Advil, Motrin, or its equivalent) *For headache, discomfort, fever*
Dimenhydrinate (Dramamine or its equivalent) *For motion sickness, nausea, vomiting*
Diphenhydramine (Benadryl or its equivalent) *For allergic reaction, rash*
TUMS (or equivalent) *For upset stomach, heartburn*

Please mark one of the following:

☐ I **do not** give permission for my student to be administered any listed over the counter medication at any time during the field trip, per package instructions.

☐ I **do** give permission for my student to be administered over the counter medications as needed during the field trip, knowing that all medications will be administered to my child by a designated chaperone, per package instructions.

We give our consent for the above student to participate in the designated field trip. We authorize any duly qualified and licensed physician and / or surgeon to perform any and all medical services that he/she may deem necessary, in the event that such emergency treatment is required. We expect that every effort will be made to contact us as soon as possible.

_____ _____
Parent/legal guardian signature Date

**WEST SALEM SCHOOL DISTRICT**
**MEDICAL FORM FOR OVERNIGHT FIELD TRIPS**

Kate Brohmer RN, BSN District Nurse
WSHS Office (608) 786-1220 | WSHS Fax (608) 786-1273 | Nurse Cell: 608-451-1185 | brohmer.kate@wsalem.k12.wi.us

## MEDICATIONS (PROVIDED BY PARENT)

| Name of Medication | Dosage/Frequency | Time(s) of Administration | To Be Given By |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

***THIS SECTION IS TO BE COMPLETED IF STUDENT WILL SELF-ADMINISTER MEDICATIONS.***

**Parent/Guardian Consent:** I give permission for my child to self-administer the above named medications (except controlled substance medications) in accordance with the above instructions and guidelines for overnight field trips. I am aware and understand there will be no adult supervision regarding self-administration of the medications and my child is aware that sharing of any medication for any reason is strictly prohibited. I release the School District of West Salem and associated personnel from any liability claims as a result of the administration of the medication(s) as directed.

_____ _____ _____
***Date*** ***Parent/Guardian's Signature*** ***Phone***

**Student Consent:** I understand that I will be responsible for self-administering my own medication in accordance with the above instructions. I am aware that under no circumstances is any medication to be shared with any one.

_____ _____ _____
***Date*** ***Student's Signature*** ***Phone***

**Healthcare Provider Order (For Prescription Medications Only):** The above medication(s) may be self-administered in accordance with the above instructions.

_____ _____ _____
***Date*** ***Healthcare Provider's Signature*** ***Phone***

***THIS SECTION IS TO BE COMPLETED IF STUDENT WILL HAVE MEDICATIONS ADMINISTERED BY DESIGNATED STAFF.***

**Parent/Guardian Consent:** I authorize that the above named medication(s) may be administered during the activity indicated on the front of this form in accordance with the School District of West Salem Medication Policy. The Healthcare Provider may be contacted if needed. I release the School District of West Salem and associated personnel from any liability claims as a result of the administration of the medication(s) as directed.

_____ _____ _____
***Date*** ***Parent/Guardian's Signature*** ***Phone***

**Healthcare Provider Order (For Prescription Medications Only):** The above medication(s) may be administered in accordance with the above instructions.

_____ _____ _____
***Date*** ***Healthcare Provider's Signature*** ***Phone***