Eugene School District 4J

Extended Field Trip – Student Health and Emergency Information
Authorization for Medication Administration

Parent/ Guardian: Please complete and sign this form. This is a required form in order for your student to participate in the extended field trip. If you have any questions, please contact your child's teacher or the school administrator.

STUDENT & CONTACT INFORMATION

_____ *Student name*	_____ *Date of birth*	_____ *Grade*
_____ *Teacher /School*	_____ *Field Trip*	_____ *Trip Dates*
_____ *Primary Contact (Legal Guardian)*	_____ *Primary Phone*	_____ *Relationship*
_____ *Secondary Contact (Legal Guardian)*	_____ *Primary Phone*	_____ *Relationship*

Emergency Contacts If Parent/Legal Guardian Cannot Be Reached:

_____ *Emergency Contact #1*	_____ *Primary Phone*	_____ *Relationship*
_____ *Emergency Contact #2*	_____ *Primary Phone*	_____ *Relationship*

HEALTH & MEDICAL INFORMATION

Allergies

_____ Food
_____ Medication
_____ Bee, insect bites or stings
_____ Poison oak
_____ Grass/ pollen
_____ Latex
_____ Other, _____
_____ None

Provide specific information about allergen, nature of allergic reaction, and treatment needed:

Significant Medical Conditions

_____ Asthma
_____ Severe Allergies
_____ Seizures
_____ Diabetes
_____ Bleeding Disorder
_____ Other, _____
_____ None

Provide specific information about medical condition or other health concern, including treatment that may be needed during field trip.

Dietary Restrictions – Provide list any dietary restrictions:

_____ None

Activity Restrictions – Provide list any activity restrictions:

_____ None

Other Special Precautions and Pertinent Information/ Instructions – Please identify any other precautions, health or safety concerns, or other pertinent information about your child, including any recent exposure to infectious disease (chicken pox, pink eye, strep throat etc…) in the last two weeks:

_____ None

By signing this form, I authorize the exchange of health information about my child, as necessary, between appropriate school personnel, the school nurse, an authorized 4J service provider (such as a third party outdoor school program provider), and/or my child's health care provider in the interest of my child's safety and well-being on the trip.

_____	_____	_____
Print Parent Name	**Parent Signature**	**Date**

MEDICATION ADMINISTRATION INFORMTION

Parent/ Guardian: If your child will or may need essential or emergency medication while on an extended field trip, please complete page 3 (for each medication). Medication includes prescription and non-prescription (over-the-counter) medications. Students are not allowed to carry their own medication except as provided by district policy.

FDA approved over-the-counter and prescription medications must be provided by the student's parent or legal guardian. Please deliver any medication in its original factory or pharmacy-labeled container in a plastic zip bag with the child's name on the outside to school personnel before the trip. Do not mix medications. Each medication must be separately packaged in its original container. For student safety, ALL medications will be kept and their use supervised by trained 4J school staff or registered nurse of an approved 4J provider/ contractor.

Non-prescription sunscreen may be administered by school personnel without written authorization from parents. If you have an objection to the administration of sunscreen, please note it on this form.

Nonprescription medications, including vitamins, supplements or herbal remedies not approved by the FDA may only be dispensed to students if it is accompanied by a written order from the student's prescriber that includes the name of the student, name of the medication, dosage, method of administration, frequency of administration, and a statement that the medication must be administered while the student is in school, any other special instructions, and the signature of the prescriber.

RETURN FORM TO SCHOOL PERSONNEL

AUTHORIZATION FOR MEDICATION ADMINISTRATION
BY SCHOOL PERSONNEL

Student's Name_____ Birthdate_____
School Name_____ Grade_____

I am giving school personnel permission to administer medications to my child per the following:
Parent to complete separate form for each medication. If dosage, time or frequency for medication administration changes at any time in the future, parent must complete a new form.

Medication: _____ _____ Non Prescription (*sin receta)*
Medicina
Dose (how much):_____ _____Prescription *(receta)* Rx number_____
Dosis Exp Date:_____
Frequency (how often): _____ _____Please allow my child to self-administer this
Frequencia medication (refer to district medication policy)

Route: (circle one)
By: Mouth Ear Eye Nose Skin
Boca oido ojo nariz piel
Time: _____
Hora
Duration: Start date_____ end date_____
Fechas para empezar y terminar
Reason for Medication: _____
La razon para la medicina

Special Instructions:
_____

Health care provider's name is:_____and phone is _____.

I am the parent or legal guardian of the student listed above, and I give permission for 4J School Personnel to administer the medication listed above to my child. This authorization is valid only for the duration of the above-named field trip. For purposes of medication administration, the term "4J School Personnel" includes an authorized 4J service provider, such as a third party outdoor school program provider, designated by the principal to administer medication and trained as provided by district rule. I authorize 4J School Personnel to exchange information, as necessary, between appropriate school personnel, the school nurse, contracted third-party service provider and/or my child's health care provider in the interest of my child's safety and well-being on the trip. *I understand I am responsible to provide this medication in the* ***most current pharmacy container with accurate label*** *or* ***manufactured packaging*** *and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes.*

Print Parent Name: _____

Parent Signature: _____ **Date:** _____

ADMINISTRATOR APPROVAL*
(When necessary for self-administration of medication, see JHCD/JHCDA-AR - Medications)

Administrator
Signature:_____Date:_____

RETURN TO SCHOOL PERSONNEL

Office: Copy to School Nurse and Teacher; Original to Student Health File

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