BOYERTOWN AREA SCHOOL DISTRICT
FIELD TRIP AUTHORIZATION FORM
(PLEASE COMPLETE ALL SECTIONS OF THIS FORM)

Child's Full Name____Date________________________

Teacher____Cost________________________

Place_______________________________________Location__________________________________

Departure date/time ____________________________Return date/time___________________________

*If you wish to allow your child to participate in this trip, please sign the form below, detach it, and return it to the sponsoring teacher by ______________. If you do not wish to have your child participate, simply do not sign the form. The child will then attend all classes as regularly schedule on the day of the trip.

AUTHORIZATION

_____________________________________has my permission to participate in the educational field to ___________________________

on____________________________________.

I understand that reasonable precautions will be taken to safeguard my child while on the trip. If my child would need professional medical attention while on this trip, please act on my behalf. Therefore, I hereby authorize medical treatment for my son/daughter, __________________________, in case of an emergency and in the event I cannot be contacted.

MEDICAL HISTORY (PLEASE NOTE "NONE ", IF THIS DOES NOT APPLY TO YOUR CHILD)
**Please list any allergies (food/drug/environmental) or medical conditions of your child.

____

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***MEDICATION:** Includes prescribed, over-the-counter, and supplemental medications that are either daily medications, as needed medications (inhalers, allergy related medication,etc.) and/or emergency medications (Benedryl, Epi-pen, etc.). **Choose one of the following**:

____________My child **WILL NOT** need medication during this trip

____________My child **WILL** need medication during trip hours

Medication Name_________________________________

_________Please use the medication currently in the health room for this trip ('Authorization for School Medication Administration is already on file)

_________I will provide the medication to be used on this trip (Complete and return 'Authorization for School Medication Administration' form) For your convenience, an authorization form is provided on back.

EMERGENCY CONTACT INFORMATION

(MOTHER) HOME( )_________________WORK ( )____________________CELL( )___________

(FATHER) HOME( )_________________WORK( )____________________CELL( )___________

PARENT/GUARDIAN SIGNATURE______________________________DATE_____________________

*Please refer to the student handbook for detailed medication policy. Authorization Form for Medication Administration can be found at http://www.boyertownasd.org/UserFiles/File/forms/Health/Medication_Request_Form.pdf or contact the school nurse or copy back of permission form.

Revised 12/2007

Form #38

COMPLETE THIS SIDE ONLY IF STUDENT REQUIRES MEDICATION TO BE ADMINISTERED DURING FIELD TRIP

BOYERTOWN AREA SCHOOL DISTRICT
AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION

Child's Full Name: ____ Grade/Homeroom: ________________________

Date of Birth: ______________________ Allergies: ____

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PHYSICIAN'S REQUEST

Name of medication (OTC, Prescribed, Vitamins):____
Reason: ____ Route: __________________________________
Side Effects: ____ Time and dose(s) to be given at home
____ Time and dose(s) to be given at school:
____

Medication is to be administered:
1._____ until completed. Date: _______________
2._____ entire school year: daily _____ prn _____
3._____ other: ____
___* I believe this child is able and responsible to carry and self-administer his/her inhaler and/or Epi-Pen during school, on field trips, and at extra-curricular activities upon clearance by their physician, parent and school nurse. S/he has permission to do so and has been instructed on how to self-administer (Gr. K-12).
___** I believe this child is able and responsible to carry and self-administer the medication on certain field trips and at extra-curricular activities. S/he has permission to do so and has been instructed on how to self-administer (Gr.6-12 only).

____ ____
PHYSICIAN'S SIGNATURE **PRINTED NAME**

_____________________ ____
DATE **PHONE NUMBER**

** *****

PARENT REQUEST

I, the parent/guardian of ______________________________ request that the Boyertown Area School District nurse administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Boyertown Area School District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injury in connection with administration of the prescribed medication.

Additionally, I agree to hand deliver the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication and medical condition.

____* I believe my child is able and responsible to carry and self-administer his/her inhaler and/or Epi-Pen during school, extra-curricular activities and on field trips. I give my permission for him/her to do so (Gr. K-12).
____** I believe my child is able and responsible to carry and self-administer his/her medication on certain field trips and at extra-curricular activities. I give my permission for him/her to do so (Gr.6-12).

_______________ ____
DATE **PARENT/GUARDIAN SIGNATURE**

List all medications currently being taken by this child: ____

In accordance with Boyertown's Medication policy:

*Students in **Grades K-12** may carry and self-administer his/her inhaler and/or Epi-Pen during school, on field trips, and at extra-curricular activities upon clearance by their physician, parent and school nurse. Your initials indicate that the child is capable of proper medication administration.

** Students in **Grades**: **6-12 ONLY** may carry and self-administer his/her medication on certain field trips and at extra-curricular activities upon clearance by their physician, parent and school nurse. Your initials indicate that the child is capable of proper medication administration.

All medication forms must be completed and on file in your child's school health room before medication can be administered.

______Clearance to carry and self-administer an inhaler and/or Epi-pen has been given by the school nurse
Revised 5/2007

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