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 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 ____

Physician's Phone: Day: ________________________ Night: ____

Preferred hospital in case of emergency ____

Please list any medical conditions/concerns: ____

____

____

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

____

____

If your child has Asthma, please give more information regarding triggers/frequency/severity/treatment of attacks:

____

____

If your child has diabetes, please provide specific information regarding level of self-care and other specific needs to your child: ____

____

____

If your child has a seizure disorder please provide information regarding triggers, type of seizure and frequency: _______

____

If your child has allergies to food, insects, medications or other allergens, please list them and describe the type of reaction: ____
____

Does your child need a special diet? ________ If yes, explain:____
____

Circle any condition needing bottom bunk: Bedwetting____ Frequent urination ____Sleepwalking____ Seizures____ Restlessness____ Other____ Further explanation: ____

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) RMAE

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 School Health Aide **4** weeks prior to departure allowing for necessary review and planning.
- All medications must be checked in to the School Health Aide 1 week prior to departure.
- Please review the parent checklist to make sure all information is complete.

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

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: _______

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: ________________________________ Date: ____________________

Please list all medications going on the trip and below. Remember that each medication must have the medication agreement (see below in blue and 1 form per medication) to be administered on the trip.

EACH MEDICATION MUST HAVE A MEDICATION AGREEMENT (this is the live link) FORM SIGNED BY MEDICAL PROVIDER & PARENT

Medication #1: ____
CHECK ONE: As needed ____ Daily ____

Medication #2: ____
CHECK ONE: As needed ____ Daily ____

Medication #3: ____
CHECK ONE: As needed ____ Daily ____

Medication #4: ____
CHECK ONE: As needed ____ Daily ____