WILMINGTON PUBLIC SCHOOLS
Wilmington, MA
FIELD TRIP CONSENT FORM

STUDENT NAME_____ D.O.B. _____ ROOM/Grade_____

Place _____ Date _____ At a cost of _____

Cash or check payable to _____.

In the event of an emergency during which we cannot be reached, we hereby give permission to the bearer of this form to allow any doctor or medical facility to administer an anesthetic and perform such emergency procedures as may be necessary for our child.

We hereby release and hold harmless the Town of Wilmington, its agents, servants or employees from any liability and/or responsibility for any damages or injuries sustained by our child while under your care, not caused by the lack of due care by the Town of Wilmington, its agents, servants or employees duly authorized.

- **VERY IMPORTANT:** The following information **must be completed in full** in order for the child to participate. **Please be sure to indicate all telephone numbers requested as well as insurance information and policy numbers.**

This information will be the only information traveling with the group on the day of the field trip

Home Address:_____ **Home Phone:**_____

Parent/Guardian #1 Name:_____ **Work Phone:**_____ **Cell:**_____

Parent/Guardian #2 Name:_____ **Work Phone:**_____ **Cell:**_____

Emergency Contacts (Other than parent) Name: _____ **Phone#**_____

Name: _____ **Phone#**_____

- **Health Ins. Co.**_____ **Policy #**_____

Allergies (food, insects, medicine, environment): _____

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LIST ANY **SIGNIFICANT HEALTH PROBLEMS** (i.e. Diabetes, Seizure Disorder, Asthma, etc.):

_____

_____

If applicable, your child's daily medication on-hand at school will be administered by a School Nurse or designee. Please note PRN medications (i.e. Ibuprofen, Acetaminophen, etc) may only be administered upon completion of an assessment by a nurse. In addition, student specific emergency medication, such as Epinephrine and Glucagon will accompany students on all field trips.

I would like my child to take advantage of the above named field trip.

_____ _____

REQUIRED PARENT/GUARDIAN SIGNATURE **DATE**

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Medication Administration Plan

List all Prescription & Over-the-Counter Medications Your Child will be taking on the Field Trip:

STUDENT'S NAME_____ D.O.B. _____ ROOM/Grade_____

#1 MEDICATION NAME	DOSE	ROUTE of Administration	TIMES TO BE GIVEN
POSSIBLE SIDE EFFECTS/ADVERSE REACTIONS:			

#2 MEDICATION NAME	DOSE	ROUTE of Administration	TIMES TO BE GIVEN
POSSIBLE SIDE EFFECTS/ADVERSE REACTIONS:			

#3 MEDICATION NAME	DOSE	ROUTE of Administration	TIMES TO BE GIVEN
POSSIBLE SIDE EFFECTS/ADVERSE REACTIONS:			

#4 MEDICATION NAME	DOSE	ROUTE of Administration	TIMES TO BE GIVEN
POSSIBLE SIDE EFFECTS/ADVERSE REACTIONS:			

#5 MEDICATION NAME	DOSE	ROUTE of Administration	TIMES TO BE GIVEN
POSSIBLE SIDE EFFECTS/ADVERSE REACTIONS:			

DATE_____ **PARENT/GUARDIAN SIGNATURE**_____

DATE_____ **PHYSICIAN SIGNATURE****_____

***Per MDPH regulations, a Physician Signature is required for all prescription and nonprescription medications on this form, unless already currently on-file in the nurse's office.*

For School Nurse Use Only
Designated Staff Person to Administer Medication: _____
Designated Staff Person completed:

- ☐ WU: Administration of Field Trips by Delegation, Role & Responsibility of the Teacher
- ☐ WU: Life-threatening Allergies & Epinephrine Training
- ☐ Reviewed Medication Administration Plan with the School Nurse

School Nurse Signature: _____ Date: _____