Overnight Medical Release Form Instructions for Parents/Guardians

- All students must have a completed ***Overnight Field Trip Medical Release*** form. Forms must be turned in no later than 2 weeks before scheduled trip. (Please have this form notarized, most local banks will do this for a small fee) ***Emergency Allergy/Asthma Plan*** must be photocopied on the backside. This form is effective for the entire school year. Any questions about the form(s) can be directed to the school nurse office at (920) 563-7805.
    1. Students with severe allergies that require the use of an Epi-pen or Benadryl need to complete the **top** portion of the ***Emergency Allergy/Asthma Plan***. Signature(s) required at the bottom.
    2. Students with Asthma must complete **bottom** portion of the ***Emergency Allergy/Asthma Plan***. Signature(s) required at the bottom.
- Student who will be taking medication during an overnight trip must have a completed ***Administering Medication to Students*** form for **each** medication that is to be administered (See #3 & #4 for exceptions).
    1. Prescription medication must have both the parent **and** health care provider signatures. The medication must come in the original container dispensed from the pharmacy.
    2. Non-prescription medications need only the parent's signature unless the dose exceeds the manufacturer's recommended dosage, which then requires a health care provider signature. Over the counter medication must be in the original container. Please label the container with your child's name.
    3. Medications for Asthma/Allergies are covered on the ***Emergency Allergy/Asthma Plan*** (reverse side of medical release). Medication forms are not needed when parent and health care provider signatures are completed on the ***Emergency Allergy/Asthma Plan.***
    4. Any medications that students routinely take at school and have an ***Administering Medication to Students*** form on file do not require an additional form. Please indicate this on the ***Overnight Field Trip Medical Release*** form.

School District of Fort Atkinson
Overnight Field Trip Medical Release Form

Student's Name: _____
Street Address: _____
City: _____ Zip: _____
Date of Birth: _____

Medical Insurance Information:
Provider: _____
Contact #: _____
Group #: _____

Health Care Provider: _____
City: _____ State/Zip: _____
Phone: _____

Parent/Guardian: _____
Address: _____
Home #: _____
Work #: _____
Cell # or Pager: _____

If unable to reach parent/guardian, please notify:
Name: _____
Relationship: _____
Home #: _____
Cell # or Pager: _____

***Forms must be returned to school no later than 2 weeks before scheduled trip. Please contact the nurse's office with questions at (920)563-7805.

Student's General Health Information:

1. Does your child take **medication**? YES or NO
   Will your child require medication during this trip? YES or NO
   [A completed and signed ***Administering Medication to Student Form*** is required for each medication (prescription or over-the-counter) to be administered during the field trip]
   My child has a current medication form on file. YES or NO
2. Does your child have any **allergies**? YES or NO If yes, please list: _____
   [If your child requires **medication to treat severe allergic reactions,** complete the allergy section on the reverse side (*Emergency Allergy/Asthma Plan.)* Please note signatures required at the bottom].
3. Does your child have **asthma**? YES or NO
   [If yes, complete the asthma section on the reverse side (*Emergency Allergy/Asthma Plan.)* Please note signatures required at the bottom].
4. Is there any health history that may assist the person in charge if this student should become ill?
   _____
   _____
   _____

Trip Consent/Authorization to Seek Medical Treatment:

I give permission for above listed student to participate in overnight field trips. The undersigned parents/guardians, in the event that he or she cannot be contacted through reasonable efforts, does hereby empower and grant the School District of Fort Atkinson personnel permission to consent to and authorize dental, medical and hospital care and treatment for the above student. This authorization shall be valid for the duration of the current school year. I do hereby indemnify and hold harmless the physicians, hospital and other persons who act in reliance upon the authorization. NOTE: Your signature on this form acknowledges your acceptance of financial responsibility for any medical or dental care your child requires.

_____
Signature of Parent/Guardian Date

_____
Signature of Notary Date

_____
State County Date Commission Expires

EMERGENCY ALLERGY/ASTHMA PLAN

Allergy Action Plan

Name: _____ Date of Birth: _____

Allergy to: _____

Antihistamine (brand & dose) _____

Epinephrine (brand & dose) _____

Physician: Please check option A, B, or C for school staff to follow:

___A. Give Epi-pen immediately upon exposure to listed allergen

___B. Give Epi-pen should **any** of the following severe symptoms occur after exposure to allergen:

- Wheezing or difficulty breathing, repetitive cough
- Change in voice quality (hoarseness, high pitch)
- Hives (raised rash) over body
- Swelling of the lips and/or tongue

___C. Give Antihistamine first (listed above) for mild symptoms (itchy mouth or lips, few hives or mild itching, mild nausea).

If symptoms persist or become severe, administer Epi-pen.

When giving Epi-Pen immediately do the following in this order:

1. Give Epi-Pen injection
2. Call the Rescue Squad (911) to transport and treat student for shock
3. Notify parent/guardian

SIGNATURES REQUIRED- SEE BELOW

Asthma Action Plan

Triggers: _____

The following are possible signs of any asthma emergency:

- difficulty breathing, walking, or talking
- blue or gray discoloration of the lips or fingernails
- failure of medication to reduce worsening symptoms

These signs indicate the need for emergency medical care. The steps that should be taken are:

- call 911
- call parent/guardian or physician

Current Medication-Indicate if taken at school

Medication	Dosage	Time

Steps for an Acute Asthma Episode (to be completed by physician)

1. _____
2. _____
3. _____
4. _____

PARENT/GUARDIAN SIGNATURE _____ DATE_____
(Signature required for all prescription and non-prescription medication)

PHYSICIAN SIGNATURE _____ DATE_____
(Signature required for all prescription medication and for non-prescription medication that exceeds the manufacturer's recommended dosage)