MILLIS PUBLIC SCHOOLS
Overnight School Sponsored Field Trip, Activity, or Program
Medical Form for Students

Program Information:

Title or Name of Field Trip, Activity, or Program _____

Dates _____

Location _____

Student Information:

Student's Name _____

Home Address _____

Parent/Guardian Phone _____ Cell Phone _____ Pager _____

Health Insurance Provider _____

Health Insurance Policy Number _____

Primary Subscriber of Medical/Health Policy _____

Student's Primary Health Care Provider _____ phone # _____

Health History:

Allergies (food, medicine, and environment)

_____

Chronic Health Conditions and Significant Medical History:

_____

Date of Last Tetanus Shot _____

*** Please complete and have your child's medical provider sign authorization for all medications (including over the counter medications) to be self administered ***

Please return this medical form (via mail or fax) to the Millis Public Schools

Medications

- ☐ All medications must be in original pharmacy labeled container with child's name, dosage, route, and frequency of administration (include asthma inhalers, Epi Pens, and all regularly or occasionally taken medication)
- ☐ Provide only the amount of medication needed for the duration of the trip
- ☐ Please ensure that your child is capable of self administering his/her medication

- ☐ All medications to be self administered must have the medical provider's signature of written authorization completed on this form, except for short term prescription medication in pharmacy labeled container (for example: antibiotics)

Please **complete the following chart with information of all medications** (prescription and non prescription) that the student will need to self administer during the trip:

Medication	**Dosage and Route to administer**	**Frequency or time to take medication**	**Reason to take medication**	**Potential side effects**

Medical Provider's authorization:
I authorize the following child _____ to self- administer the above listed Medications.

_____

Print and Signature of medical provider **date**

***My Child will NOT self-administer any medications _____ (please initial)**

Parent/ Guardian Consent and Release

☐ I/We, the undersigned parent/guardian, give permission for my child to self-administer the above listed medications. I agree to release, indemnify and hold harmless the Town of Millis, the Millis School Committee and their employees and agents from and against any claim either I or my child may have as a result of any act or omission which may arise out of this authorization.

☐ I/We further consent to urgent medical treatment by a health care provider in the event of illness or injury of our child during his/her participation in the trip/ activity/ program. I/We accept full responsibility for all costs for any medical treatment.

☐ I/We consent for the release of confidential medical information to be released to and from medical providers, the faculty of the Millis Public Schools, and the school trip/ activity/ program chaperones, as needed to maintain my child's health and safety.

_____ **Date** _____
Parent/Guardian Signature (only one signature required)

Reviewed by School Nurse: _____ **Date** _____