STOUGHTON PUBLIC SCHOOLS

OVERNIGHT AND OUT OF STATE FIELD TRIP

MEDICAL FORM

Program Information

Program Coordinator: _Mr. John I. Mange -_Fine Arts Director

Title or Name of Field Trip, Activity, or Program: SHS Band and Choir NYC Music Trip

Dates: _April 17th - April 19th, 2020_____

Location(s) of Event: New York City, New York

Location of Nearest Medical Facility for Emergency Care: ___To be determined

Student Information

Student's Name: _____ DOB: _____

Home Address: _____

Parent/Guardian Name: _____

Phone Number (s): Home: _____

Cell: _____

Work: _____

Emergency Contacts:

Name: _____ Phone #: _____

Name: _____ Phone#: _____

Health Insurance Information:

Company: _____

Policy #: _____

Primary Subscriber: _____

Student's Primary Health Care Provider: _____

Phone #: _____

Student's Name _____

Health History:

Allergies (circle): Yes No If Yes, specify: _____

Epi-Pen (circle): Yes No

Asthma (circle): Yes No Inhaler: (circle): Yes No

Chronic Health Conditions and Significant Medical History:

_____

_____

Last Tetanus Shot Date: _____

Do you know of any health factor that would make it advisable for your child to follow a limited program of physical activity during this trip?

_____

_____

Parent Authorization:

- This health history is correct to the best of my knowledge, and the student herein described has permission to engage in all physical activity related to the trip.
- I 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 accept full responsibility for all costs for any medical treatment.
- I consent for the release of confidential medical information to be released to and from medical providers, the faculty of the Stoughton Public Schools, and the school trip/activity/program chaperones, as needed to maintain my child's health and safety.

_____ _____

Parent/Guardian Signature Date

MEDICATION ADMINISTRATION

All of the signatures noted below are required for all overnight field trips or travel.

- All medication must be in original pharmacy labeled container with student's name, dosage, route, and frequency of administration (include asthma inhaler, Epinephrine, and all regularly or occasionally taken medication).
- Medications will be stored with a teacher or student (whichever is deemed the safest method by the school nurse).
- 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 school nurse's signature of written authorization completed.

Please complete the following medication administration plan 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
Acetaminophen	Per School Physician's Order		
Ibuprofen	Per School Physician's Order		

Per Massachusetts Administration of Prescription Medications in Public Schools regulations (105 CMR 210.006), self-administration of medications is permitted with school nurse and parent/guardian approval. In order for your child to self-administer medication, there must be an order from a licensed prescriber permitting self-administration, and a parent/guardian must complete part A of this form. Part B will be completed in the school nurse's health office with your child.

Part A. Parent/Guardian Consent and Release for Self-Administration:

- I, the undersigned parent/guardian, give permission for my child to self-administer the listed medications: _____

- I understand that self-administration means that the student is able to consume medication in the manner directed by the licensed prescriber, without additional assistance or direction.

- My child has been instructed in and understands the purpose, appropriate method, frequency and use of the medication.

- My child understands that they are responsible and accountable for carrying and using their medication. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying the medication will be rescinded.

- I will support my child in following the agreement in Part B.

_____ _____

Parent/Guardian Signature Relationship to Student

_____

Date

Part B. To be completed by the school nurse:

	Yes	No
Student is consistently able to:		
Name the medication		
Identify the correct medication		
Explain the purpose of the medication		
State the correct dosage		
Explain when the medication is to be taken		
Describe what will happen if the medication is not taken		
Student demonstrated the correct use/administration.		
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees not to share the medication(s) with others.		
The student agrees to follow the agreed upon documentation procedure of self-administration of medication.		
The student agrees to notify an adult immediately with any questions, concerns or adverse side effects.		
The student understands that the privilege of carrying and administering his/her own medication(s) will be rescinded if he/she does not follow the above agreement.		

_____ _____ _____ _____

Student Signature Date School Nurse Signature Date

Stoughton Public Schools
SCHOOL TRIP
Medical Form Addendum re: Confidentiality and HIPAA Privacy

The Massachusetts Department of Public Health Privacy Officer and the Office of the General Counsel have concluded, that physicians and other licensed providers whose business activities (such as that of a school nurse) fall under the HIPAA (Health Insurance Portability and Accountability Act), (45CFR I64.512 b) regulations are considered that of a hybrid entity. This means that the Department of Public Health, as a whole, is considered a covered entity whose business activities include both covered and non-covered functions.

Determining that the Department is a hybrid entity also means that the release of PHI (Patient Health Information) from a covered component to a non-covered component is considered a disclosure under HIPAA and not permitted unless there is an individual authorization or a specific exemption aloowing the disclosure. The Privacy Rule requires the Department, and those working under the Department, to assure that PHI is not improperly disclosed.

Given the above noted, I give authorization for the School Nurse to share information with the licensed Registered Nurse / Parental volunteer who will be attending the upcoming trip that my child _____ will be attending.

The licensed registered Nurses who will be attending the trip will sign a confidentiality waiver, and any information shared with them for the purposes of providing health care to your child will be kept in strict confidence in provision with the HIPPA laws.

Parent / Guardian Consent

_____ Date _____

parent / guardian signature