CANTON PUBLIC SCHOOLS

Overnight and Travel Out of State Field Trips
Superintendent/School Committee Request Form

CHS ☐ **GMS** ☐ **HANSEN** ☐ **JFK** ☐ **LUCE** ☐

GRADE: _______ **TEACHER(S) IN CHARGE:** ______________________________

1. **Submit to Nursing and Administration at least ONE MONTH prior to trip departure date.**
2. **Complete all of the following information.**

Program Information:

Destination of Field Trip, Activity: ______________________ , ______________, __________
Venue City State

Date(s): ____

Location of nearest medical facility for emergency care: ______________________________

Relevancy to Teaching Unit:

What is your current lesson plan: ______________________________

Educational Value of Trip: ______________________________

What do you have for follow-up plans? ______________________________

Program Specifics:

Time of Departure: __________ **Time Scheduled to Return:** ___________

Number of Students Attending: _______________ **Cost per Student: $** ____________

Number of CPS Chaperones: __________________ **Number of Additional Chaperones:** __________________

Total Number Substitute Staff needed: __________

Transportation: ______________________________

Initial Principal Approval: ____________________ **Date** _________________

Superintendent and School Committee approval are required.

Allow a minimum of one month for planning

☐ **Approved by Superintendent** ______________________________ **Date** _______________

☐ **Approved by School Committee** ____________________________ **Date** _______________

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10/8/13, rev 8/12/14

CANTON PUBLIC SCHOOLS

Overnight and Travel Out-of-State Field Trips

Parent/Guardian Permission and Medical Form for Students

(3 pages must be completed)

Please return this form to your trip coordinator at least ONE MONTH prior to trip departure date.

Program Information:

Program Coordinator: ______________________________

Title or Name of Field Trip, Activity, or Program: ______________________________

Dates: ______________________________

Location(s) of event: ______________ (Venue), ______________ (City), ______________ (State)

Location of nearest medical facility for emergency care: ______________________________

Student Information:

Student's Name: ______________________________

Home Address: ______________________________

Parent/Guardian Phone: ______________ **Cell #1:** ______________ **Cell #2:** ______________

Emergency Contact: ______________ **Phone:** ______________ **Cell:** ______________

Health Insurance Provider: ______________________________

Health Insurance Policy Number: ______________________________

Primary Subscriber of Medical/Health Policy: ______________________________

Student's Primary Health Care Provider: ______________ **Phone#** ______________

Health History:

Allergies (specify): ______________________________

Epi-Pen (circle): Yes No

Asthma: Yes No **Inhaler:** Yes No

Chronic Health Conditions and Significant Medical History: ______________________________

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Medications:

- All medication must be in original pharmacy labeled container with student's name, dosage, route, and frequency of administration (include asthma inhalers, EpiPens, and all regularly or occasionally taken medication). Please place in a labeled zip lock bag.
- Medications will be stored with teacher or student.
- 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 on page three of this form.

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	Parent/Guardian Signature
Acetaminophen (Tylenol)	325 - 650 mg orally	Every 4 hours as needed	Headache, pain, fever	
Ibuprofen (Advil, Motrin)	200 - 400 mg orally	Every 6 hours as needed	Headache, pain, fever	

** **Refer to Page 3 for Medication Administration Consents**

Additional Medical Information:

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Student Name ________________________

MEDICATION ADMINISTRATION

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

Parent/Guardian Consent and Release for Self-Administration:

- **I, the undersigned parent/guardian, give permission for my child to self-administer the above listed medications, including Acetaminophen and Ibuprofen. I agree to release, indemnify and hold harmless the Town of Canton, the Canton 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 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 Canton Public Schools, and the school trip/activity/program chaperones, as needed to maintain my child's health and safety.**

______________________________ ______________________
Parent/Guardian Signature **Date**

School Nurse Authorization for Self-Administration:

If student will not be self administering, refer to next section for delegation.

I authorize the following child ______________________________ **to self-administer the listed medications above.**

______________________________ ______________________
Signature of School Nurse **Date**

Delegation of Prescription Medications:

The responsibility for administering my child's prescription medication has been delegated to the following individual(s): ____

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______________________________ ______________________
Parent/Guardian Signature **Date**

______________________________ ______________________
Signature of School Nurse **Date**

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