# WESTPORT COMMUNITY SCHOOLS

## Office of School Health Services

Dear Parent/Guardian:

This packet contains medical forms for students attending the 8th grade Washington D.C. field trip during **June 4 to June 7, 2024**. **All students** are required to have a new **Student Medical Update Form (pg.2)** completed by the parent/guardian so the nurse has the most up to date information for reference.

The school physician has authorized a **standing order for both Tylenol and Ibuprofen**. This means you do not need to obtain an order from your child's private physician for either of these over the counter (OTC) pain medications, **but we do require your consent**. Please complete the **Parental Consent Form for Tylenol and Ibuprofen (pg.3)** and return to the nurse.

We would like to inform you of the policies that have been put in place, in accordance with Massachusetts General Laws and The Nursing Practice Act, to ensure the health and safety of children needing medications during the Washington D.C trip. **ANY MEDICATION, PRESCRIPTION or OTC, other than Tylenol and Ibuprofen, must have a written order from the students Physician AND parental consent.** If such medication is necessary, Westport Community Schools require the following to be submitted to the Westport Jr/Sr High School health office **by May 10, 2024.**

1. **Prescription Medication** – such as medication for asthma, allergies, anxiety, ADHD, insulin, etc. require an order from the Physician: **Medication Order Form (pg.4)** signed by the Physician and **Parent Consent Form (pg.5)** signed by the parent/guardian giving permission for the nurse/chaperone to administer the medication.

2. **Over the Counter (OTC) Medication** - for ALL over the counter medications **except Tylenol and Ibuprofen**; for example: Dramamine, Bonine, Zyrtec, Claritin, Pepto Bismol, Melatonin etc. the **Over-the-Counter Medication Form (pg.6)** must be signed by both the Physician and the Parent/Guardian.

3. **4 days worth of medication** - Medication in **original/current prescription container** (bottle/box from pharmacy) with **pharmacy label attached** or in **original packaging** if OTC. Please provide only the quantity of medicine needed for the duration of the trip. Medicines should be delivered to the school by a parent/guardian or a responsible adult whom you designate, **NOT BY STUDENTS.**

**Expired prescriptions will not be accepted. Loose pills in a plastic bag will not be accepted.**

If your child already has doctors orders for medications in the school health office, these do not have to be duplicated. Contact the school nurse about whether your child needs these medications and orders to accompany them on the field trip.
These forms are available from the health office. **Please submit all medications and forms to the school nurse no later than Friday May 10, 2024. Please review the orders for accuracy before sending them in. No changes can be made by the nurse.**

Please feel free to contact the WMHS Health Office if you have any questions.

# WESTPORT COMMUNITY SCHOOLS

## Office of School Health Services

## Student Medical Update – Washington D.C. trip

(Please complete and return to school immediately. Contact school nurse with any questions)

Student Name _____ M / F
Last First Middle

Date of Birth ___/___/___ Health insurance name & number _____
(attach copy of card to this form)

Parent/Guardian contact #1 _____ Phone_____

Parent/Guardian contact #2 _____ Phone_____

Physician: _____ Phone_____

Student Medical History (please circle all that apply and detail below)

| | | | |
|---|---|---|---|
| Anxiety | Diabetes | Liver Disease | Past Surgeries (specify) |
| Autism | Down Syndrome | Motion Sickness | _____ |
| ADD / ADHD | Genetic Disease | Scoliosis | _____ |
| Asthma | Gastrointestinal Problems | Seizures | |
| Birth Defect | Headaches | Skin Condition | |
| Bleeding Disorder | Head Injury | Urinary Problem | |
| Cancer | Heart Condition | Vision Problems / Wears glasses (Yes / No) | |
| Cerebral Palsy | High / Low Blood Pressure | Hearing Problems (Right / Left) | |
| Depression | Kidney Disease | Ear tubes / Wears hearing aid (Right / Left) | |
| Developmental Delay | Emotional Issues | Other: _____ | |

_____

(Use back of form if you need more space for details)

Allergies (food, medication, environmental) _____

Is emergency treatment required? (Circle one) Yes No

If yes, with what medication(s)? _____

Does your child use daily medication? Yes (please list) No

_____

_____

(**All** medications given on school field trips must have a physician's order, parental consent and be transported to school by an ADULT)

In case of a medical emergency, the school will attempt to contact the parent/guardian before calling an ambulance or the student's physician. Your child will be transported by ambulance to an emergency care facility if necessary. I give permission for the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.
I give permission for chaperones/volunteers to provide basic first aid to my child while on the Washington DC field trip.

_____ _____
Parent/Guardian Signature Date

# WESTPORT COMMUNITY SCHOOLS

## Office of School Health Services

Parental consent form- Standing orders for overnight field trip to Washington D.C., June 4-7, 2024

Tylenol (Acetaminophen) for students age 12 and up:
650mg every 4 hours as needed for pain, fever, menstrual cramps (maximum 5 doses in 24 hour period)

Ibuprofen for students age 12 and up:
400mg every 6 hours as needed for pain, fever, menstrual cramps (maximum 3 doses in 24 hour period)

I give permission to have the school nurse or school personnel designated by the school nurse to give the above medicine to my child during the Washington D.C. overnight field trip on June 4-7, 2024.

STUDENT NAME

Signature of Parent/Guardian Date

# OVERNIGHT FIELD TRIP MEDICATION ORDERS

## Washington D.C. 8th Grade Field Trip

**Westport Community Schools**
**Westport, MA 02790**

MEDICATION ORDER
(to be completed by a Licensed Prescriber)
Physician, Nurse Practitioner or others authorized by Chapter 94C

Name of Student_____ Date of Birth_____

Address_____ Grade_____
(street) (city/town)

Name of Licensed Prescriber_____ Title_____

Business Phone Number_____ Emergency Phone Number_____

**Medication**_____

**Route of Administration**_____ **Dosage**_____

**Frequency**_____ **Time(s) of Administration**_____

**Specific directions or information for administration:** _____

Duration of order: **6/4/24-6/7/24 Washington D.C. 8th Grade Field Trip**

Diagnosis (if not in violation of confidentiality) _____

Any other medical condition(s)*_____

**Consent for self administration (provided the school nurse determines it is safe and appropriate) Yes_____ No_____**

**Consent for carrying own medication (inhaler or Epipen only). Yes _____ No_____**

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed:_____
2. Other medications being taken by the student:_____

_____
Signature of Licensed Prescriber

# OVERNIGHT FIELD TRIP MEDICATION PARENTAL CONSENT

## For Prescription Medications

**Washington D.C. 8th Grade Field Trip**
**Westport Community Schools**
**Westport, MA 02790**

WRITTEN PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Sex: M___ F___

Name of Parent/ Guardian: _____
(Please Print)

Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Other persons to be notified in case of an emergency if parent/ guardian unavailable:

Name: _____ Relationship: _____ Telephone : _____

My son/daughter is currently receiving the following medications (to be completed if not a violation of confidentiality). Please list all medicines the child is receiving, including those given during the school day.

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

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CONSENT FORM

1. I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine

   _____prescribed by
   Name of Medicine

   _____ to _____.
   Licensed Prescriber Name of Student

2. I give permission for my son/daughter to self- administer the above medication if the school nurse determines it is safe.
   Yes_____ No_____

3. I give permission for my son/daughter to carry their own medication if approved by the nurse.
   (only inhaler or Epipen). Yes_____ No_____.

4. I give permission to the school nurse to share with school personnel information relative to the prescribed medicine, e.g. adverse side effects as he/she determines necessary for my son's/daughter's health and safety

   Yes_____ No_____ Any restrictions on release? _____

***Please note: I understand that I must bring only a 4 day supply of the medicine to the school by 5/10/24***

Signature of Parent/ Guardian _____ Date _____

# OVERNIGHT FIELD TRIP MEDICATION PARENTAL CONSENT

**Washington D.C. 8th Grade Field Trip**

## Over the Counter Medications

The Westport Community Schools require a doctor's order and parental consent for authorization to administer "Over the Counter" OTC medication to students in accordance with Massachusetts Law. This form will allow the parent/volunteer Nurse to administer medication if your child is not feeling well during the field trip.

**If you and the Physician feel your child can self administer please indicate by initialing the columns on the right.**

Name of Student _____ Date of Birth ___/___/___

Address _____

Contact Person 1 _____ Phone _____

Contact Person 2 _____ Phone _____

Student's allergies _____

Student's medical conditions _____

| | | | | | | | Self Administration | |
|---|---|---|---|---|---|---|---|---|
| | Name of Medication | Dose | Route | Frequency | Time | Side effects | Parent | Physician |
| Pain Medication | | | | | | | | |
| Allergy Medication | | | | | | | | |
| GI Medication | | | | | | | | |
| Vitamins | | | | | | | | |
| Cold Medication | | | | | | | | |
| Other | | | | | | | | |
| Other | | | | | | | | |
| Other | | | | | | | | |

I agree that the above medication may be administered to this student as ordered during the overnight field trip.

**Physicians Name (printed)** **Physicians Signature** **Phone number**

I give permission for my child to receive the above medications from the parent/volunteer Nurse during the overnight field trip.

**Parent/Guardian Name (printed)** **Parent/Guardian Signature**

Please note that the Parent/Guardian **must provide the OTC medication in its original container** labeled with the students first and last name. Both the Physician and Parent/Guardian must sign above for medication to be administered.