

**Greeneville City Schools
School Health Services**

Field Trip Medication Notice

Dear Parent/ Guardian,

We are excited that your student is going to be a part of our school field trip. In order to provide a safe, simple, and efficient means of providing medication for our students during the trip we have developed the following plan.

- Trained school personnel will carry and manage all medications available during a school trip with the exception of medications that are eligible for self-carry under state law.
- All medications that are authorized for self-carry require the parent/guardian to provide the school with the appropriately signed paper work.
- No student should be carrying any medication without proper authorization.
- Any student who has unauthorized medication in his/her possession will be subject to discipline which may include dismissal from the trip that requires the parent to pick up his/her child.

As a convenience for parents we have trained school staff who will be carrying some basic over the counter medications (i.e. Tylenol, Ibuprofen, cough drops, etc.—see list on permission form) during the trip. It is up to each parent/guardian to decide whether they would like for these medications to be available to their child.

If your child needs other medications not included in our over the counter list or if you prefer to send the students own supply of a medication be sure to complete the following checklist and make sure all permission slips and medications are turned into the school. If your child is to receive **any medication that is not a part of the basic over the counter supply** (prescription or nonprescription) while away from the school for school related activities all of the following list must be completed.

1. Permission forms must be **completed, signed, and returned** to the school **with the medication** in order for trained school staff to assist your child with self-administration of medications.
2. **All medication must be sent in their original containers.** Send the exact amount of medication to be given during the field trip whenever possible.
3. Prescription medications must be labeled by the pharmacy and all non-prescription medications must be in the **original manufacturer's container** with the **child's name** affixed to the container.
4. Please place all medication in a zip-lock bag with the child's name on the bag and return to school with the completed medication form(s) **no later than: _____.**
5. Additional forms may be obtained from the school or the Coordinated School Health Office.

If you have any questions or need clarification regarding which medications can be self-carried (for example, inhalers, diabetic medications, Epi-pens) or which forms are required to allow your student to self-carry the medication please call me at 823-2916 or Rhonda Ratliff, Nursing Supervisor at 552-6827.

Jeannie Woolsey, RN
Coordinated School Health Supervisor
Greeneville City Schools
Phone: 423-823-2916

Greeneville City Schools

School Health Services

OFF CAMPUS ACTIVITIES CONSENT FOR EMERGENCY MEDICAL TREATMENT

To be completed by parent/guardian with custodial rights. Please print.

Student Full Name: _____

Date of Birth: ____/____/____ **Sex:** ____ M ____ F **School:** _____

Parent/Guardian Name: _____

Home Address: _____

Phones Home: _____ **Work:** _____ **Cell:** _____

Parent/Guardian Name: _____

Home Address: _____

Phones--Home: _____ **Work:** _____ **Cell:** _____

Alternate Emergency Contact (other than parent/guardian)

Name: _____ **Relationship:** _____

Address: _____

Phones--Home: _____ **Work:** _____ **Cell:** _____

Student's Primary Doctor: _____ **Office Phone:** _____

Address of Physician: _____

Student's Insurance: _____

Policy #: _____ **Group #:** _____

Name of Primary person insured: _____

(PLEASE SEND A COPY, FRONT AND BACK, OF THE INSURANCE CARD)

Parental / Guardian Consent for Medical Treatment

I hereby give consent for the above named student to be given medical treatment in the event of an injury or illness while under the supervision of Greeneville City Schools' personnel during off campus activities. I also understand that it may be necessary to transport my child to the nearest medical facility depending on the child's illness or injury via ambulance. I understand that I will be responsible for any bills arising out of medical treatment. My signature indicates that I am giving consent to medical treatment in the event of an illness or injury and that consent is granted for any off campus activity for the entire school year.

Parent/Guardian Signature: _____

Date: _____

Administration of Medications During Off Campus Activities for Greeneville City School Students

Student Name: _____ Date of Birth: _____

Grade: _____ School: _____ Teacher (elementary only) _____

ALLERGIES (PLEASE LIST) include beestings, food allergies, and MEDICATION allergies.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

List all medication your child takes on a routine basis that should be given on this trip:

Name of Medication	Strength	Dosage	Times to be taken	Purpose

Special instructions regarding medications and/or allergies:

_____ **Date of Last**

Tetanus Shot: _____

List below any additional health information that the staff should be aware of:

School personnel will be carrying the medication listed below. To give permission for your student to be treated with these medications while on this trip you must check the medications that may be given—IF YOU HAVE NOT GIVEN US PERMISSION TO ADMINISTER THE MEDICATIONS BY CHECKING THE APPROPRIATE LINES YOUR STUDENT WILL NOT RECEIVE ANY OF THESE MEDICATIONS WHILE ON THE TRIP. Medications will be dosed according to manufacturer’s recommendations.

- | | | |
|------------------------------|--|------------------|
| ____ Acetaminophen (Tylenol) | ____ Benadryl (generic--liquid/caps) | |
| ____ Hydrocortisone Cream 1% | ____ Anti-itch cream/spray | ____ Cough Drops |
| ____ Ibuprofen | ____ Antibiotic Cream/Ointment. (Non-prescription) | |
| ____ Antacids | | |
| ____ Contact lens cleaner | | |

OTHER: _____
PLEASE LIST – BE SPECIFIC!!!!

Please list any medications that your child **should not have:** _____ **Additional permission forms are available at school or online at www.gcschools.net under District forms/Coordinated School Health/Off Campus Activities.**

The undersigned parent/guardian hereby agrees to release the Greeneville City School System and its personnel from any legal claim they now have or may thereafter have arising out of the assistance with self-administration of or failure to administer medication to the student. I will assume full responsibility for any side effects and complications that my child may have as a result of medications.

Parent/Guardian Signature: _____ Date _____