

**CANTON PUBLIC SCHOOLS**  
**Overnight and Travel Out-of-State Field Trips**  
**Parent/Guardian Permission and Medical Form for Students**  
**(ALL pages MUST be completed)**

Please return this form to you 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(s): \_\_\_\_\_

City(s): \_\_\_\_\_

State(s): \_\_\_\_\_

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: \_\_\_\_\_

---

**Health History:**

Allergies (specify): \_\_\_\_\_

Epi-Pen (circle): Yes No

Asthma: Yes No Inhaler: Yes No

Chronic Health Conditions and Significant Medical

History: \_\_\_\_\_

Canton Public Schools do not discriminate on the basis of race,color, religion, national origin, sex, sexual orientation,  
gender identity, age, or disability.

**Medications:**

- All medications must be in original pharmacy labeled container with student’s name, dosage, route and frequency of administration (including asthma inhalers, EpiPens and all regularly or occasionally taken medications). Please place in labeled zip lock baggie.
- Medications will be stored with teacher or student, as indicated by parent/guardian below.
- Provide only the amount of medication needed for the duration of the trip.
- If indicated below, please ensure that your child is capable of self-administering their medication.

Please complete the following medication plan with the information of all medications needed during the trip

<u>Medication</u>	<u>Dosage/Route To administer</u>	<u>Time to take medication</u>	<u>Reason to take medication</u>	Self-administer by student (circle y/n)	Administer by delegated staff (circle y/n)	Parent/ Guardian Signature
				YES NO	YES NO	
				YES NO	YES NO	
				YES NO	YES NO	
				YES NO	YES NO	
Acetaminophen (Tylenol)	325-650 mg Orally	Every 4-6 hours As needed	Headache, pain, fever	YES NO	YES NO	
Ibuprofen (Advil, Motrin)	200-400 mg Orally	Every 6 hours As needed	Headache, pain, fever	YES NO	YES NO	

Additional Medical Information:(use back if needed)

**Delegation of Prescription Medications**

The responsibility of administering my child’s medication has been delegated to the following individual(s): \_\_\_\_\_

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**School Nurse Authorization for Self-Administration**

I authorize the following student, \_\_\_\_\_, to self-administer the above listed medications.

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

Canton Public Schools do not discriminate on the basis of race,color, religion, national origin, sex, sexual orientation, gender identity, age, or disability.

**Parent/Guardian Consent:**

- **I, the undersigned parent/guardian, give permission for my child to self-administer or for delegated staff to administer the above listed medications. 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 healthcare provider in the event of illness or injury of my child during their participation in the trip/activity/program.**
- **I accept full responsibility for all costs for any medical information to be shared 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 \_\_\_\_\_