Field Trip Name: _____

Logos International School

2021-2022 Field Trip Medical Release & Consent

Student's Name: _____ **Grade**: _____
(Last) *(First)*

Male or Female: _____ **Date of Birth:** _____
(day/month/year)

A. Parent/Guardian Contact Information:

#1 Name_____ Relationship:_____Phone:_____

#2 Name_____Relationship:_____Phone:_____

B. Allergies:

Check (✔) box if **None** ☐

Food allergy:	Reaction & treatment:
Medication allergy:	Reaction & treatment:
Other allergies:	Reaction & treatment:

C. Medical Conditions:

Check (✔) box if **None** ☐

1. Please list any medical conditions or special dietary needs that we should be aware of:

_____
_____
_____

2. Are there any specific activities that need to be limited or avoided? Please Check (✔) box ☐YES ☐NO

If yes, please explain: _____

MEDICATIONS TO BE ADMINISTERED ON TRIP**

(Including inhalers, prescription, over-the-counter, and herbal medication) Check (✔) box if **None** ☐

Medication Name & Dose	
1.	**3.**
2.	**4.**

** All student medication will be administered by a Logos staff member only. A **Medication Authorization Form** must be filled out for medication to be given. All medication needs to be labeled properly with: name, dosage, and preferably kept in original packaging with a visible expiration date.

D. Consent

As parent/guardian, I give my child permission to participate in this trip organized by Logos International School. As parents/guardians, I understand and acknowledge that my child/student may have an accident resulting in personal injury or bodily damage while participating in the activities. As the parents/guardian of the student, I understand and acknowledge that Logos International School is exempt from all actions, claims, costs, expenses or damages of any kind related to the activity of Logos International School in which the student or a member of the immediate family of the student participates. I further acknowledge that this is a full and complete release for all injuries and damages which the student or immediate family may sustain as a result of participating in the Logos International School activity.

In case of a medical emergency, I give permission for any necessary treatment/medication to be administered to my child by a teacher, physician, nurse, dentist, hospital, and/or paramedics. This may include a Logos teacher administering Paracetamol for fever and/or Chlorpheniramine for an allergic reaction.

Parent signature:_____ Date: _____
(day/month/year)

Relationship to the student: _____

Field Trip Name: _____

Medication Authorization Form

(CONFIDENTIAL)

For students to receive medication sent from home, this form must be filled out by a parent/guardian along with **proper labeling of medication sent. Please label medication with name, dosage, and preferably kept in original packaging along with the expiration date visible.*

Student's Name _____ **Grade**_____
(Last name) (First name)

Date of Birth _____ **Any Allergies?** _____
(day/month/year)

1. **Medication Name** _____ Dosage _____
   Method/Route _____ Time(s) of Administration_____
   Start Date _____ End Date _____
   Medical problem for which this medication is being administered:_____
   _____
   Any specific instructions for administration: _____
   _____
2. **Medication Name** _____ Dosage _____
   Method/Route _____ Time(s) of Administration_____
   Start Date _____ End Date _____
   Medical problem for which this medication is being administered:_____
   _____
   Any specific instructions for administration: _____
   _____
3. **Medication Name** _____ Dosage _____
   Method/Route _____ Time(s) of Administration_____
   Start Date _____ End Date _____
   Medical problem for which this medication is being administered:_____
   _____
   Any specific instructions for administration: _____
   _____

The school nurse will administer medication to students according to this form. In the case of a school sponsored event that occurs off-campus, a trained staff member will be responsible for medication administration.

Signature of Parent/Guardian _____ **Date** _____
(day/month/year)

Relationship to student _____ **Mobile Phone**_____

Signature of School Nurse _____ **Date** _____

** **For Students with Asthma and/or Anaphylactic Allergies Only****

Permission for self-administration: student may carry with them an inhaler and/or an epinephrine cartridge injector(circle which one) as long as they have the permission of a parent and the school nurse. When provided with, additional emergency medication will be kept in the school office in an unlocked, clearly labeled cupboard.

❏ Yes, my child has permission to carry his/her emergency medication if applicable.

Signature of Parent/Guardian _____ Date _____
Approval signature of School Nurse _____ Date _____