

Puerto Rico Trip Health/Medication Reminders

Dear Parents and Guardians:

As we get closer to the Puerto Rico trip June 17-24, 2017, there are a few health reminders and forms that are REQUIRED to be filled out and returned. If your child has any special health needs or if they will need **ANY type of medication** to go along with them on this trip, the Health Office needs to know. This includes non-prescription over the counter medications (including cough drops, eye or ear drops, Tylenol, Benadryl etc.) and prescription medications (Allergy, ADHD medications, asthma inhalers, antibiotics etc.). In order for your child to receive medications, we must have written permission from the student's parent/guardian AND doctor*. No student will be permitted to take any medications on their own (parent may administer to their child, however policy notes we still need medical forms completed).

If you want to send medication on the trip for your child, you need to do the following:

1. We need your written consent and your health care provider's written authorization to give the medication. *The medication **cannot and will not** be given without both of these consents in advance of departure date. Use the attached "Authorization for administration of medication at school" form.* Have your doctor complete it fully, parent/guardian needs to sign it and then bring the completed form to the health office.
2. **Return completed forms as soon as possible to the health office.** Medications should be sent with your child the day of departure and be packed in the child's suitcase. Prescription medication must be in the original prescription bottle. Over the counter medications must be in their original bottle/package. Please check to make sure medications are not expired. Expired medications will not be given. **Medications may NOT be sent in envelopes or baggies without the original packaging label.** Labels on medication must be clear and able to read.

IF WE DO NOT HAVE THE PROPER MEDICATION CONSENTS PRIOR TO THE TRIP, MEDICATION CANNOT BE GIVEN TO YOUR CHILD.

****this IS according to the Minneapolis Public School Medication Administration Policy- exemptions CANNOT be made.***

Sincerely,

Traci Cruikshank, RN, Licensed School Nurse

James Clark, Principal

**Recordatorios de Salud/Medicamentos
Del Viaje a Puerto Rico**

Como ya nos acercamos a la fecha del viaje a Puerto Rico que será del 17 al 24 de junio, tengo algunos recordatorios en el área de la salud y también unos formularios que TIENEN que llenar y devolver a la oficina. Si su hijo/a tiene alguna necesidad especial o si necesita **CUALQUIER tipo de medicamento** para llevar en este viaje, la Oficina de la Enfermera necesita saberlo. Esto incluye medicamento sin prescripción (incluyendo caramelos/pastillas para la tos, gotas para los ojos/oídos, Tylenol, Benadryl) y medicamentos con prescripción (medicamentos para alergias, hiperactividad (ADHD), inhaladores para asma, antibióticos, etc.) Para que a su hijo se le administren el/los medicamentos, debemos tener una autorización por escrito de parte de los padres/tutores Y también por parte del doctor.* A ningún estudiante se le permitirá tomar medicamentos por sí mismos (los padres pueden darle la medicina a su hijo/a, sin embargo las políticas establecen que de cualquier manera hay que completar los formularios).

Si usted quiere enviar medicamentos en el viaje para su hijo/a, usted necesita hacer lo siguiente:

1. Necesitamos su consentimiento y el de su médico por escrito para poder administrar el medicamento. Los medicamentos **no serán administrados** si no tenemos ambos consentimientos por adelantado antes de la fecha de partida. Utilice el formulario adjunto llamado "**Autorización para Administrar Medicamentos en el Plantel Escolar**". Pídale a su doctor que lo llene, y el padre/tutor deberá firmarlo y traerlo debidamente completado a la Oficina de la Enfermera.
2. **Devuelva el formulario debidamente lleno tan pronto pueda a la Oficina de la Enfermera.** Los medicamentos deben ser enviados con su hijo/a el día del viaje y ser empacado en la maleta de su hijo/a. Medicamentos con prescripción deberán estar en el recipiente original. Medicamentos sin prescripción deberán estar en el recipiente original. Por favor asegúrese de que el medicamento no ha expirado. Medicamento que haya expirado no será administrado. Los medicamentos NO podrán ser enviados en sobres o bolsitas plásticas sin la etiqueta original del recipiente. Las etiquetas de los medicamentos debe ser clara y legible.

SI NO TENEMOS LOS CONSENTIMIENTOS MEDICOS REQUERIDOS ANTES DEL VIAJE, NO SE PODRA ADMINISTRAR NINGUN MEDICAMENTO A SU HIJO/A.

Esto es en acuerdo con la póliza de Administración de Medicamentos de las Escuelas Publicas de Minneapolis – No haremos ninguna excepción

Sinceramente,
Traci Cruikshank, RN, Licensed School Nurse
James Clark, Director



Minneapolis Public Schools
Health Related Services



Overnight Field Trip Student Health Information Form

Field Trip/Destination: Puerto Rico Date(s) of trip: June 17-24, 2017

Dear Parent/Guardian: Please complete the following health information form and sign below. This information will help field trip staff be aware of the health concerns & needs of participating students.

Student Name: _____ Teacher/Grade: _____

Address: _____

Parent/Guardian: _____ Phone #: _____ Cell #: _____

Alternate Emergency Contact: _____ Phone #: _____

Insurance Company: _____ Policy #: _____

Health History Information: Please check all that apply.

No Health Concerns

ADHD/ADD Allergies (to what?): _____

Asthma Bladder/Bowel Problems (Describe): _____

Diabetes, Type: _____ Exposure to drugs and/or alcohol before birth

Heart Problems Is the student pregnant? Due date: _____ Does the student have children? _____

Seizures, Type: _____ Sleep Concerns (Nightmares, Sleepwalks, etc.): _____

Social/emotional/behavioral/mental health concerns (Describe): _____

Activity Restrictions (Describe): _____

Recent exposure to communicable diseases (If yes, explain): _____

Recent surgeries or hospitalizations (If yes, explain): _____

Date of Student's last tetanus shot: _____

Please describe any other special medical conditions, information or directions: _____

Is your Student currently taking any medication? Yes No If yes, Specify Medication(s): _____

The Licensed School Nurse will NOT be available outside of school hours. All questions regarding medications and/or treatments occurring outside of school hours will be directed to the parent/guardian. No on-site or off-site nursing supervision will be provided for this event and parent(s)/guardian(s) will need to be available for calls and emergencies. **911 or emergency medical services will be called in the event of a medical emergency and the student will be transferred to the nearest medical facility**

If your child requires **ANY MEDICATION** on the field trip, the backside of this form must be completed and returned with the parent/guardian and physician signatures.

The above named student has my consent to take the field trip as described. This health information may be shared with MPS School Staff as needed.

Parent/Guardian Signature: _____ Date: _____

Please Turn Over and Complete Back Side for Medications ➔



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Health Related Services



Date: _____
Entered in Disc. _____
Scanned to WebNow _____

Authorization for Administration of Medication at School

Parents/guardians asking school staff to give medications to their child must provide (written) permission every school year that has been signed by parent/guardian and the child's health care provider.

Student: _____ BD: _____ ID#: _____
School: WINDOM DUAL IMMERSION School year: JUN 17-24, 2017 Grade/Rm: _____

Physician/licensed prescriber's order for Administration of Medication by School Personnel

** Medical Diagnosis & ICD-10-CM Code MUST be completed by Physician/Licensed Prescriber **

Medical Diagnosis	ICD-10-CM Code	Medication	Dose	Time	Route	Possible Side Effects
1.						
2.						

Other considerations/directions: _____

Start date: _____ Stop date: _____
(All authorizations expire at the end of the school year or following the summer school session.)

Signature of Physician/Licensed Prescriber _____ Print name of Physician/Licensed Prescriber _____ Date _____

Clinic address _____ Phone _____ Fax _____

Parent/Guardian Authorization

- I request that the above medication(s) be given during school hours as ordered by my child's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
- I will notify the school of any change in the medication(s), (i.e., dosage change, medication is stopped, etc.).
- I give permission for the medication(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.
- Legally, I may refuse to sign for the medication. If I refuse to sign, we will not be able to administer the medication at school.
- This consent may be revoked at any time, by sending a written notice to the licensed school nurse.

NOTE: Medication must be supplied in original/prescription bottle.

Permission for Release of Information

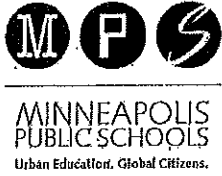
- I give permission for the school nurse to communicate, as needed, with school staff about my child's medical condition(s) and the action of the medication(s).
- I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by medication(s).
- I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the licensed school nurse.

Parent/Guardian Signature _____ Date _____ Relationship to Student _____

Return to: TRACI CRUICK SHANKS, RN Phone: 612-668-3379 Fax: 612-668-3380
RN, Licensed School Nurse

TO BE COMPLETED BY HEALTH CARE PROVIDER

TO BE COMPLETED BY PARENT/GUARDIAN



Escuelas Públicas de Minneapolis
Servicios relacionados a la salud



Formulario de información de la salud del estudiante para
paseos escolares en los que pasan la noche

Paseo escolar y destino: PUERTO RICO

Maestro(a)/grado: _____ Fecha (s) del viaje: JUNIO 17-24, 2017

Estimado padre/tutor: Por favor complete el siguiente formulario de información de salud. Esta información ayudará a los miembros del personal que acompañan a los estudiantes en la excursión a estar consciente de algún problema o necesidad que los estudiantes tengan por su salud.

Nombre del estudiante: _____

Número de teléfono del hogar: () _____ Dirección del hogar: _____

Nombre del padre/la madre/ el tutor: _____

Número de teléfono del trabajo: () _____ Número de teléfono del celular: () _____

Nombre del contacto de emergencia: _____

Número de teléfono del contacto de emergencia () _____

Compañía de seguro médico: _____ Número de póliza: _____

Información de historial médico: Por favor marque todas las que apliquen:

- | | | |
|---------------------------------------------------|-----------------------------------------------------------|------------------------------------------------|
| Asma <input type="checkbox"/> | Pesadillas <input type="checkbox"/> | Condición del corazón <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Enuresis nocturna (moja la cama) <input type="checkbox"/> | Dolores de estómago <input type="checkbox"/> |
| Convulsiones <input type="checkbox"/> Tipo: _____ | Sonambulismo <input type="checkbox"/> | Infecciones de oído <input type="checkbox"/> |
| ADHD <input type="checkbox"/> | Se desmaya con facilidad <input type="checkbox"/> | Otro: _____ |

Alergias: _____

Sensibilidad a la hiedra venenosa, zumaque o roble (Poison Ivy, Sumac u Oak): _____

Fecha en que se le suministró la última vacuna contra el tétano: _____

¿Existe alguna razón por la que se deba limitar la actividad de su hijo(a)? Sí No

Si contestó afirmativamente, por favor explique a continuación: _____

¿Su hijo(a) ha sido expuesto recientemente a alguna enfermedad contagiosa? Sí No

Si contestó afirmativamente, por favor explique a continuación: _____

Si su hijo(a) padece de algún otro tipo de condición médica, tiene algún tipo de información o instrucción, por favor descríballo a continuación: _____

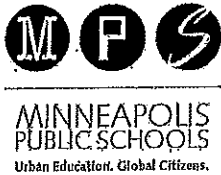
¿Su hijo(a) está tomando algún tipo de medicamento actualmente? Sí No

Si contestó afirmativamente, por favor explique a continuación: _____

Si su hijo(a) requiere TOMAR ALGÚN MEDICAMENTO durante la excursión o paseo escolar que aún no ha sido suministrado en la escuela, la parte trasera o el reverso de este formulario debe de ser completado y devuelto 5 días antes de la fecha de salida y debe ser firmado por los padres/el padre y el médico.

- Se llamará al 911 o a los servicios de emergencias médicas si ocurre una emergencia médica y el estudiante será transferido al hospital o clínica más cercana.

Por favor, voltee la página y complete la parte de atrás →



Escuelas Públicas de Minneapolis
Servicios relacionados a la salud



**Formulario de información de la salud del estudiante para
paseos escolares en los que pasan la noche**

Paseo escolar y destino: Puerto Rico

Maestro(a)/grado: _____ Fecha (s) del viaje: June 17-24, 2017

Estimado padre/tutor: Por favor complete el siguiente formulario de información de salud. Esta información ayudará a los miembros del personal que acompañan a los estudiantes en la excursión a estar consciente de algún problema o necesidad que los estudiantes tengan por su salud.

Nombre del estudiante: _____

Número de teléfono del hogar: () _____ Dirección del hogar: _____

Nombre del padre/la madre/ el tutor: _____

Número de teléfono del trabajo: () _____ Número de teléfono del celular: () _____

Nombre del contacto de emergencia: _____

Número de teléfono del contacto de emergencia () _____

Compañía de seguro médico: _____ Número de póliza: _____

Información de historial médico: Por favor marque todas las que apliquen:

Asma

Pesadillas

Condición del corazón

Diabetes

Enuresis nocturna (moja la cama)

Dolores de estómago

Convulsiones Tipo: _____

Sonambulismo

Infecciones de oído

ADHD

Se desmaya con facilidad

Otro: _____

Alergias: _____

Sensibilidad a la hiedra venenosa, zumaque o roble (Poison Ivy, Sumac u Oak): _____

Fecha en que se le suministró la última vacuna contra el tétano: _____

¿Existe alguna razón por la que se deba limitar la actividad de su hijo(a)? Sí No

Si contestó afirmativamente, por favor explique a continuación: _____

¿Su hijo(a) ha sido expuesto recientemente a alguna enfermedad contagiosa? Sí No

Si contestó afirmativamente, por favor explique a continuación: _____

Si su hijo(a) padece de algún otro tipo de condición médica, tiene algún tipo de información o instrucción, por favor descríbalo a continuación: _____

¿Su hijo(a) está tomando algún tipo de medicamento actualmente? Sí No

Si contestó afirmativamente, por favor explique a continuación: _____

Si su hijo(a) requiere TOMAR ALGÚN MEDICAMENTO durante la excursión o paseo escolar que aún no ha sido suministrado en la escuela, la parte trasera o el reverso de este formulario debe de ser completado y devuelto 5 días antes de la fecha de salida y debe ser firmado por los padres/el padre y el médico.

- Se llamará al 911 o a los servicios de emergencias médicas si ocurre una emergencia médica y el estudiante será transferido al hospital o clínica más cercana.

Por favor, voltee la página y complete la parte de atrás ➔



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EXTENDED FIELD TRIP – NATIONAL/INTERNATIONAL TRAVEL STUDENT AGREEMENT FORM

Your Name (please print)

Name of School Sponsoring Trip

Your Student ID No.

Title of Trip

Sponsoring Teacher/ Group

Student Agreement:

1. I agree that this planned trip experience is an extension of my school classroom.
2. I agree that the chaperones are responsible for helping me make the best of this learning experience.
3. I understand and agree that chaperones will make decisions regarding my daily schedule, my permitted activities and my behavior while on this trip.
4. I agree to follow the directions given me by the chaperones on this trip.
5. I agree to meet the expectations for appropriate student behavior and to abide by all Minneapolis Public School policies, including the Citywide Discipline Policy, and policies regarding controlled substances and weapons, bullying, hazing, harassment and violence.
6. I agree that I will not use alcohol or any other controlled substance while I am a participant on this trip even though the location of the trip might permit others of my age to use these substances legally.
7. I understand and agree that my failure to follow the directions of my chaperone, or failure to follow district policies may result in my being sent home at my parent's expense, and that my family will not be entitled to any reimbursement for any amounts we have paid for me to participate in this trip.
8. I understand that I may not make any individual excursions during the term of this trip.
9. I understand that I must remain with my assigned group and chaperone at all times.
10. I agree that I will ask the sponsoring teacher or staff for help to resolve any issues I encounter that might prohibit my successful completion of this trip.
11. I understand that I represent myself, my family, my school and my community on this trip, and will strive to represent them honorably at all times.
12. I affirm that the sponsoring teacher or staff member has reviewed this agreement with me and answered all of my questions regarding it.

Student signature

Date



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EXTENDED FIELD TRIP – NATIONAL/INTERNATIONAL TRAVEL VOLUNTEER CHAPERONE AGREEMENT FORM

Your Name (please print)

Name of School Sponsoring Trip

Your Address

Title of Trip

Your Phone No.

Your Email (if available)

Sponsoring Teacher/ Group

I Am Am not a District Employee

If an employee:

Title

School/Location of assignment

Background Information:

Your previous
experience working
with students:

Special skills: WSI, CPR, First Aid Training,
Fluency in non-English Language etc.

Have you been convicted of a misdemeanor or felony since your last criminal background check?

YES

NO

If YES: please explain:

Chaperone Agreement:

1. I understand that I have volunteered to act as a chaperone for students participating in the above described field trip, and enter into this agreement for the purposes of understanding my responsibilities. I do not expect to be paid for my services as a chaperone on this trip.
2. I understand and agree that the students are my responsibility 24 hours per day.
3. I agree that the students for whom I am made specifically responsible are part of the whole group of students participating and I will promote the concept of total group cooperation.
4. I agree that no student will be left without a chaperone at any time.
5. I agree that chaperones will meet together as a group with the sponsoring teacher or staff to discuss incidents and concerns and any other problems which may affect the success of this experience. I agree that I will follow the directions of the sponsoring teacher or staff regarding my response to incidents.
6. I agree that I will not undertake any personal excursions while I am a chaperone for the Minneapolis Public Schools on this trip.
7. I agree that I will keep the sponsoring teacher or staff aware of my location at all times while on this trip.
8. I agree that I will maximize the learning experiences available to the students on this trip to the best of my ability.
9. I agree that I will follow specific procedures of the Minneapolis Public Schools in handling problems due to illness, discipline or any emergency situation while I am a chaperone.
10. I agree that I am responsible for any travel documents required for this trip (passports, visas, or other border control required documents).
11. I certify that all the information I have provided on this form is true and complete to the best of my knowledge.

Signature

Date

FOR STAFF:

DATE OF CHAPERONE'S CRIMINAL BACKGROUND CHECK:

DATE OF CHAPERONE'S COMPLETION OF VOLUNTEER ORIENTATION:



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EXTENDED FIELD TRIP – NATIONAL/INTERNATIONAL TRAVEL PARENT/ GUARDIAN AUTHORIZATION FORM

Student Full Name _____

Student ID No. _____

Parent or Guardian Name(s) PLEASE PRINT _____

A field trip to: Puerto Rico

Is planned by: Windom Dual
Immersion School

For the purpose(s) of: Spanish immersion
experience

On:

<u>6:40</u>	<u>June 17, 2017</u>	To	<u>10:15pm</u>	<u>June 24, 2017</u>
Time of Beginning	Date Beginning		Time Ending	Date Ending

The undersigned parent(s) or guardian(s), on behalf of the above named student in consideration of participation by the student in the described trip herewith declare(s):

- 1) That I have disclosed all special health problems or disabilities of my child that may require special attention or supervision on this field trip, and made provision for the safe handling of any medication required by my child;
- 2) That the necessary arrangements, plans, supervisory arrangements and precautions being taken on behalf of my child's safety and supervision for the described trip have been explained to me and accepted by me.
- 3) That by signing this authorization agree to assume all risks of said trip to my student and to hold harmless Special School District No. 1 for all damages from injury to person or property arising out of any act not under the direct control of said School District, including but not limited to the following:

a. Insurrection, Revolution, Civil War or rebellion	d. Any act of aggression by a foreign government or its citizens,
b. Abduction or kidnapping	e. Air piracy
c. Natural disaster	f. any act, whether accidental or otherwise perpetuated by anyone not under the direct control of the School District.
- 4) That the costs of said field trip have been explained to me and approved by me, including the liability for additional costs incurred by my student for early return or medical care or treatment, loss of travel documents or due to costs incurred due to acts of my student whether of intent or negligence.

On the basis of the above, I /We authorize the above named student to participate in the field trip described.

Parent/ Guardian Signature _____

Date _____

HOME (preferred contact number)
Telephone Numbers :

Alternate Phone (Work/ Cell)

Alternate Phone # 2 (Work/ Cell)

Address: HOME addresses of all signers _____

EMERGENCY Name and telephone contact if parent/guardian cannot be reached _____