

OUT OF TOWN AND/OR OVERNIGHT

**ITHACA CITY SCHOOL DISTRICT
FIELD TRIP MEDICAL INFORMATION**

Student Name _____ Birth date _____
Home Address _____ Home Phone _____
Parent/Guardian Name _____ Work Phone _____
Parent/Guardian Name _____ Work Phone _____
Lives with: _____ Phone _____
Sponsoring Teacher(s): _____ Date(s) of Trip: _____

Names of two friends, relatives or neighbors that can be contacted if parents are not available during an emergency:

Name _____ Home Phone _____ Work Phone _____
Name _____ Home Phone _____ Work Phone _____

- 1) I state, as the child's parent/guardian, that the only major illness, injury, surgery or allergy including chronic conditions sustained by my child are as follows: _____

- 2) I understand it is my full responsibility as parent/guardian to advise the medical office in writing of any changes in my child's health status prior to the trip.

NO MEDICATIONS, INCLUDING ALL OVER-THE-COUNTER- MEDICATIONS MAY BE GIVEN TO YOUR CHILD ON A FIELD TRIP WITHOUT WRITTEN PERMISSION OF THE PARENT/GUARDIAN AND A PHYSICIAN'S SIGNED MEDICATION ORDER.

If you have a current medical order on file at the Nurse's Office, this can be attached to the field trip form. Any new medicine needs a written and signed order from a Doctor with a signed permission from a parent/guardian. Your Physician & You must indicate if the student can self-medicate. Medical forms are available in the Nurse's Office.

3) My child will be taking:

Med _____	dose _____	frequency _____
Med _____	dose _____	frequency _____
Med _____	dose _____	frequency _____
Med _____	dose _____	frequency _____

Permission to self-carry and self-medicate: YES _____ NO _____

IF EMERGENCY TREATMENT IS NECESSARY, YOUR CHILD WILL BE TRANSPORTED BY THE STAFF OR AMBULANCE TO THE NEAREST HOSPITAL. PARENTS/GUARDIANS WILL BE CONTACTED AS SOON AS POSSIBLE IN CASE OF SICKNESS OR ACCIDENT.

I GIVE PERMISSION FOR THE ATTENDING PHYSICIAN TO GIVE EMERGENCY TREATMENTS TO MY CHILD.

PARENT/GUARDIAN SIGNATURE _____ DATE _____