Our Lady of Mercy Academy

Educating young women with Faith, Compassion, and Promise

Student Health Overnight Field Trip Form

Syosset Central School District

Dear Parents:

To prepare for the overnight field trip to ________________________________, please observe the following procedures to insure the health and safety of the children.

1. In accordance with New York State Law, any child that requires medication (prescription, over-the-counter, vitamins, and supplements) must bring a written order from the child's physician. The prescription must indicate the dosage and frequency of the prescribed medication and must be in the original container.
2. Parent permission required with General Permission Form submitted to Assistant Principal.
3. Student must be instructed in proper self-administration.
4. Please complete the form below and return to the School Nurse.

Student Name: ____ Grade: ______ Age: ______ DOB: ___________

Address: ________________________________ Town: ___________________________ State: _____ Zip: _____

Parent or Guardian: ____

Address (if different): ____

Telephone Number: Cell: ____________________ Home: ___________________ Work: ___________________

Physician: ____ Phone: _________________________________

Emergency Contacts if Parent or Guardian cannot be reached:

Name: ______________________________ Number: ___________________ Relationship: __________________

Name: ______________________________ Number: ___________________ Relationship: __________________

Medical History: *Please note all information in this section is confidential*.

Is your child being treated for any medical condition? ☐ Yes ☐ No

If yes, please specify: ____

Do you know of any health factors that make limited activity necessary? ☐ Yes ☐ No

If yes, please specify: ____

Please list any allergies: ____

Date of last Tetanus Immunization: ____

Parent or Guardian Signature: ____ Date: _________________

My child takes the following medication/vitamins/supplements:

____

____

____

*Please complete the following sections if your child requires medication during the field trip.

I will supply my child with the medication in the original professionally labeled container to be self-administered by my child.

Signed: ______________________________ Date: __________ Relationship: __________

To be completed and signed/stamped by Physician only:

Student Name: ____________________________

Name of Medication: ____________________________

Dosage: ____________________________

Frequency: ____________________________

Side effects to report to MD: ____________________________

Side effects to expect: ____________________________

Name of Medication: ____________________________

Dosage: ____________________________

Frequency: ____________________________

Side effects to report to MD: ____________________________

Side effects to expect: ____________________________

____
Physician's Signature (Required)

Name of Medication: ____________________________

Dosage: ____________________________

Frequency: ____________________________

Side effects to report to MD: ____________________________

Side effects to expect: ____________________________

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Physician's Stamp (Required)