Health Permission Form for Washington, D.C. Trip – 5/21-22/19

Last Name _____ First Name_____

Address_____Home Phone _____

Mother's Name _____Work Phone _____Cell Phone _____

Father's Name _____ Work Phone _____Cell Phone _____

If parents cannot be reached in an emergency situation, we should call:

Name _____Phone #'s _____

Name of Child's Physician: _____Phone # _____

Dentist: _____Phone # _____

~~Orthodontist: _____Phone # _____~~

My child has the following allergies (foods, medications, bees, etc.): _____

And for allergic reactions takes: _____

My child's last tetanus shot was: _____

List any health problems/issues your child has: _____

List **ALL** medications your child will need to take on this trip. Do not include any vitamins as this is only a one night trip: _____

IF YOUR CHILD WILL NEED MEDICATION ON THIS TRIP, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

Medical/Treatment Consent:

I hereby give my written consent for my child _____ to receive emergency medical care while he/she is participating in activities with Beck School.

_____ _____

Parent/Guardian Signature Date

INCOMPLETE FORMS WILL BE RETURNED

PLEASE COMPLETE BOTH SIDES AND RETURN BY JANUARY 25, 2019

Medication Permission Form for Washington, D.C. Trip

Per Cherry Hill District Policy and NJ state law, parental and physician signatures are required in order for the school nurse to administer medication. No exceptions can be made.
If your child must have medication on this trip, complete this form where applicable. Place the completed form in the zip-lock bag with the medications and deliver to Mrs. Avner at Beck as soon as possible but **no later than May 3, 2019. All Medications including over the counter medicines require a doctor's order with the *exception* of Acetaminophen (Tylenol) and Ibuprofen (Advil or Motrin) which require written permission from a parent/guardian. Medicines must be in the original pharmacy bottle with the label intact. Do not include extra doses.**

Student Name: _____ Team #_____

List all drug/medicine allergies_____

Daily Medication(s):
Medication: _____

Dose: _____Administration Time: _____

Medication: _____

Dose: _____Administration Time: _____

Benadryl 25 mg_____ 50 mg_____

Administration Time: Every 4 to 6 hours_____ Other _____

Other as Needed Medications: Medication:_____ Dose:_____

_____ I authorize self-administration of an asthma inhaler/Epi Pen for the above noted student. (If applicable). If additional medication forms are needed, please call the nurse, Mrs. Avner, 856-424-4505, ext. 3132.

_____I request that the above medication(s) be given to my child by the school nurse while on the Washington, D.C. school trip.

_____ _____
Parent/Guardian Signature Date

_____I request that the school nurse administer the above medications while on the school trip to Washington, D.C.

_____ _____ _____
Physician Signature Date Stamp

Physician signature required for medication administration