ARLINGTON CENTRAL SCHOOL DISTRICT
144 Todd Hill Road
LaGrangeville, NY 12540

Health Information for Overnight School Trip

Student Name_____ **Destination** _____

D.O.B. _____ **Grade** _____ **Team/Teacher** _____

Yes	No	Check "Yes or "No"
		Has your child been diagnosed with a **life threatening allergic condition**? If yes*, specify: _____ _____. *Students requiring medical treatment for a life threatening allergy should have a doctor's order specifying the treatment.
		Does your child have an allergy to medications? If yes, specify: _____ _____
Yes	**No**	**Does your child have any of the following?**
		Asthma or RAD(Reactive Airway Disease)
		Diabetes
		Heart Problem. Specify:
		Seizure Disorder. Specify type: Date of last seizure _____
		Other conditions. Specify:
Yes	**No**	**Check "Yes or "No"**
		Does your child take any medications on a regular basis? If yes, please list: _____ _____ _____
		Will your child require any medications, (over the counter or prescription), <u>for this trip</u>? If yes, please list and provide the medication order forms: _____ _____ **1. Obtain medication orders <u>only</u> for those medications that will be necessary for your child on this trip.** **2. A doctor's order must be obtained. Please: a) refer to the instructions attached & b) use the school order form, <u>Licensed Health Care Prescriber's Medication Order for Overnight School Trip</u>.**

I understand that no medication may accompany my child on this trip, (including over-the-counter medications such as Tylenol, etc.), without the Medication Order form completed in full and submitted to the school Health Office.

Legal Guardian _____ (Signature) Relationship _____

Legal Guardian _____ (Print) Date _____

Phone # : Home _____ Work _____

Cell _____

Medical Care Provider: _____ Phone # _____

FOR OFFICE USE ONLY

Medication	Order Rec'd	Med Rec'd	As Needed	Daily	Student Carries	Notes