**The health and emergency information portions of this form are valid for all field trips/activities your child participates in. Parents are asked to update this information every ten weeks, or sooner if needed, to ensure accurate emergency information.**

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I hereby give permission to the Wallkill Central School District and/or staff designee to transport my child to/from a doctor and/or hospital for treatment. I also give my permission to allow medical treatment in conjunction with such an emergency. In addition, I give permission to the Wallkill Central School District chaperone to supervise my child taking his/her own prescription medications that I have listed below. **PRESCRIPTION MEDICATION MUST BE IN THE ORIGINAL CONTAINER AND LABELED FOR THE STUDENT FOR WHOM IT IS TO BE GIVEN. NO STUDENT WILL BE PERMITTED TO CARRY MEDICAITON, WITH THE EXCEPTION OF EMERGENCY MEDICATION SUCH AS INHALER OR EPI-PEN, ETC.** Both a written medication permission form and release form must be signed by a parent/guardian and health care provider and returned to the health office in order for the medication to be given to or carried by the student.

| **Medications** | **Times** | **Amounts** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Remaining medication will be given to the parent or Health Office Personnel**

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The following non-prescription or over the counter medication may be given to my child _____ as needed while on this trip. These medications may be given according to directions provided he or she is not allergic to the medication and it must be initialed by the parent or guardian in order to be given. Please initial.

**Only those items initialed will be provided**

1. Antacid (i.e. Mylanta, Tums, etc.) _____
2. Anti-diarrheal (i.e. Kaopectate, Immodium _____
3. Antihistamine (i.e. Hydramine, Benadryl) _____
4. Anithistamine/Topical Anti-itch (i.e. Calamine Lotion, Caladryl, Hydrocortisone) _____
5. Topical Anti-Bee Sting Solutions (i.e. after bite) _____
6. Pain reliever/Fever reducer (i.e. Non-aspirin, Acetaminophen, Ibuprofen) _____
7. Cough Syrup – Cough Suppressant/Expectorant (i.e. Guiatuess DM, Robitussin DM) _____
8. Topical/Sore Throat Spray (i.e. Chloraseptic Spray, cough drops) _____
9. Topical Ointment for Cuts/Abrasion (i.e. Bacitracin) _____
10. Decongestant (i.e. Sudafed, Pseudoephedrine) _____

## HEALTH RECORD

1. Please list all **ALLERGIES** (food, medication, plants, insects, etc.) and include symptoms, treatment procedures and the date of the last reaction._____
   _____
2. Please list (with dates) any major illness/injury your child has had, past and/or present.
   _____
   _____
3. Can your child take part in normal strenuous activity? Yes _____ No _____
4. Additional comments that will assist in the response and/or injury/illness of your child.
   _____
   _____
5. All students must have updated tetanus immunization. Date of last shot: _____