DIOCESE OF CHARLOTTE
OVERNIGHT FIELD TRIP
MEDICAL INFORMATION SHEET

SCHOOL:_____ Field trip location and date: _____

Student's Name _____DOB:_____Weight:_____

Addresss_____

Mother's Name:_____home phone:_____work/mobile:_____

Father's Name: _____ home phone:_____work/mobile:_____

Emergency Contacts: Please list 2 people that we may call in the event that the above person cannot reached.

_____relationship:_____phone:_____

_____relationship:_____phone:_____

Family Physician:_____phone:_____

Family Dentist:_____phone:_____

Please answer the following questions and comment if necessary:

1. Does your child have any current physical disabilities? No Yes _____
2. Does your child have any allergies? No Yes_____
3. Has your child been exposed to any communicable diseases in the past 3 weeks? No Yes_____
4. Has your child had any serious operations or injuries? No Yes_____
5. Does your child walk while asleep? No Yes_____
6. What was the date of your child's last tetanus shot? _____
7. Please list any recommendations or suggestions you think would help us understand your child.
   _____
8. During the field trip, the following medications will be provided. Please indicate which of these medications your child is permitted to take.

	Medication	**Dose**
_____	Tylenol as needed by mouth	dosage according to package instructions
_____	Ibuprofen as needed by mouth	dosage according to package instructions
_____	Benadryl as needed by mouth for allergic reactions	dosage according to package instructions

Parent/Guardian's/Signature: _____Date:_____

Physician Signature: _____Date: _____
(Physician signature not required if a MACS Medication form signed and on file in the health room)

If your child will need any other medications, please list them on the reverse side and provide them to the school at least 2 days before the trip in their original, properly labeled container.

STUDENT NAME: _____

Parental/Guardian Authorization

I have read the Diocese of Charlotte Medication Regulations on Medication Administration in the school setting that I was provided under separate cover. I am requesting that the medications listed below be administered as I have indicated. I hereby give my permission for my child (named above) to receive these medications during this field trip. On behalf of my child, I absolve the Diocese of Charlotte, their agents and employees from any liability whatsoever that may result from my child taking this medication.

Parent Signature: _____ Date: _____

MEDICATION	DOSAGE AND ROUTE	TIMES	Date, Time, and Initials of Person Administering Medication

Physician Signature: _____ Date: _____

Medications prepared by: _____ Date: _____

Teacher responsible for administration: _____

3/04