HAMILTON CENTRAL SCHOOL

47 West Kendrick Avenue ♦ Hamilton, New York 13346 ♦ 315-824-6400 ♦ www.hamiltoncentral.org

Mr. William Dowsland, *Superintendent of Schools* | Mr. Mark Arquiett, *Secondary Principal* | Ms. Heather Thomas, *Elementary Principal* | Mr. Kevin Ellis, *Director of PPS* | Mr. Christopher Rogers, *Director of Technology*

Form Needed for Field Trips

Medical Information & Medical Treatment Authorization

Child's Name:_____ DOB: _____ Grade:_____

Does your child have any of the following conditions?

Asthma: Yes___ No____ If yes, any medications? _____

Diabetes: Yes___ No____ If yes, any medications? _____

Seizures: Yes___ No____ If yes, any medications? _____

Other: Yes___ No____ If yes, any medications? _____

Allergies:

Medication: Yes___ No___ Type:_____ Reaction: _____

Food: Yes___ No___ Type:_____ Reaction: _____

Other allergies: _____Reaction: _____

Current treatment:

Is your child receiving treatment for ANY conditions? : Yes: ___ No: ___

If yes, for what condition? _____

What is the treatment? _____

Will your child need to take medication during the school day? Yes: ___ No: ___

If yes, you will need to fill out an "Authorization for Administration of Medication at School" form.

Medical Treatment Authorization:

I, being the parent/legal guardian of the above mentioned child, do hereby authorize Hamilton CSD faculty members to act on my behalf in authorizing unexpected medical treatment for the above named child, during the 2024-25 school year. I expect that efforts will be made to contact me (or other guardian) at the numbers below, before treatment is to be undertaken.

Parent/Guardian Name (Please Print): _____ Date: _____

Parent/Guardian Signature: _____ Phone: _____

Emergency Contact Information:

Contact 1 (Please Print): _____ Phone:_____

Contact 2 (Please Print): _____ Phone:_____

Contact 3 (Please Print): _____ Phone:_____