

**CHERRY HILL PUBLIC SCHOOLS
EXTENDED DAY FIELD TRIP MEDICAL FORM**

Student Name:	DOB:	Grade:
Destination:		Date(s) of Trip:

Your child's class will be away from school on a field trip on the date indicated above. According to the Cherry Hill Public School Administrative Procedure M-10, medication **MUST be administered by a Certified School Nurse**. Every effort is made to secure a substitute nurse for each school trip. However, it is possible that a substitute may not be available. Please read the information below carefully. If your child is not taking any medication, please indicate below. **If your child takes medication during the school day, please indicate if the dose may be withheld or if it should be given by the nurse on the trip.** Should a nurse not be available, your school's nurse will notify you.

Please note: Physician's orders and/or proper paperwork MUST be on file with the school nurse for all medications. Acetaminophen/Ibuprofen can be administered provided the ATTACHED parental consent form is **SIGNED**.

- ☐ No medication is needed
- ☐ My child's school dose of _____ may be given by the nurse.
- ☐ My child's school dose of _____ **may be withheld.**
- ☐ Due to the extended trip hours, my child will require medication. ******See attached healthcare provider order. Please use one form for EACH medication. Medication must be provided at least 1 week prior to the trip and must be brought to school by an adult. NO MEDICATION WILL BE ACCEPTED THE DAY OF THE TRIP.**
- ☐ My child has **asthma** and the **nurse** will carry my child's inhaler. *(Asthma plan must be on file)*
- ☐ My child has **asthma** and will **self-carry** an inhaler for this trip *(Asthma plan with self carry authorization must be on file)*
- ☐ My child has a life-threatening **food allergy**. The nurse or delegate will carry my child's epinephrine autoinjector
- ☐ My child has a life-threatening **food allergy** and will **self-carry** an epinephrine auto-injector for this trip *(An anaphylaxis plan with self carry authorization must be on file)*
- ☐ My student is using a brace, cast, boot, or wheelchair due to an upper/lower extremity injury or any reason that currently restricts them from physical education/activity. I have provided the nurse with medical clearance and any required accommodations. **This must be turned in and arranged prior to the morning of the trip. It may not be possible to make last minute accommodations.**

I understand that if my child becomes ill or injured during this trip, school personnel will attempt to contact me or one of the emergency contacts. If I or any of the emergency contacts cannot be reached, I understand and agree that my child will be taken to a medical facility for medical evaluation and treatment if necessary. I further agree to indemnify and hold harmless the Cherry Hill Public School District, School Board, employees, and chaperones for any injury that may occur to my child which is not the result of action or inaction by the listed representatives.

IN CASE OF EMERGENCY, PLEASE CONTACT:

Parent/Guardian #1:	Phone#:	Phone#:
Parent/Guardian #2:	Phone#:	Phone#:
Emergency Contact:	Phone#:	Phone#:
Student's Cell:		

Parent/Guardian Signature: _____ **Date:** _____