

CHERRY HILL PUBLIC SCHOOLS - OVERNIGHT FIELD TRIP FORM

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

EMERGENCY CONTACT INFORMATION:

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

Your child's class will be away from school on a field trip on the date(s) indicated above. According to the Cherry Hill Public School Administrative Procedure M-10, medication **MUST be administered by a Certified School Nurse**. Additionally, **physician's orders MUST be on file with the school nurse for all medications**. Acetaminophen/Ibuprofen may be administered provided that the parental consent form is on file for this school year. **MEDICATION MUST BE BROUGHT TO SCHOOL BY A PARENT/GUARDIAN/TRUSTED ADULT NO LATER THAN 10 SCHOOL DAYS PRIOR TO THE TRIP.** No medication is needed

- 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** and will **self-carry** an epinephrine auto-injector for this trip (*An anaphylaxis plan with self-carry authorization must be on file*)

*****High School students may be permitted to self administer certain medications as determined by the nurse. Scheduled medications (e. ADHD, antidepressants, mood stabilizers, etc) may NOT be self administered and MUST be administered by the nurse.**

Medication (s)	Dose	Frequency	Diagnosis/Purpose

- 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.
- I give permission for the school nurse to share this information on a need to know basis.
- I have attached a copy of the front and back of my child's health insurance card.**

Physician's <u>STAMP</u> (required):	Signature:	Date:
Parent/Guardian Name:	Signature:	Date:

Revised 6/2020