CHERRY HILL PUBLIC SCHOOLS - OVERNIGHT FIELD TRIP FORM

Student Name:	DOB:	Grade:
Destination:		Date(s) of trip:
STUDENT'S CELL:	Health insurance plan:	
Health insurance ID #:	Group #:	
Health Insurance Member Services Phone Number (back of card)	Phone #:	
Parent/Guardian #1	Phone #	Phone #
Parent/Guardian #1	Phone #	Phone #
Emergency contact:	Phone #	Phone #

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 Policy 5330, medication **MUST be administered by a Certified/Non-certified/Substitute School Nurse.** 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 or TRUSTED ADULT NO LATER THAN 10 SCHOOL DAYS PRIOR TO THE TRIP.**

****High school students may administer certain medications (i.e. digestive enzymes) when there is a written order from the student's health care provider, documented parent/guardian permission, reviewed by the school nurse and is in accordance with Cherry Hill School District Policy. Medications such as: ADHD, antidepressants, mood stabilizers, etc, may **NOT** be self administered and **MUST** be administered by the nurse.*

PLEASE REVIEW AND CHECK ALL THAT APPLY:

- ❏ No medication is needed
- ❏ My child will need the medication listed on the table below during the upcoming field trip. ***The healthcare provider must sign and stamp the form where indicated.* If more than five medications are needed, please contact the school nurse.**
- ❏ I am available to serve as a chaperone on this trip if needed and could dispense medication to my child.
- ❏ 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** their epinephrine 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.***

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.

Physician's **STAMP (required):**	Signature:	Date:
Parent/Guardian Name:	Signature:	Date:

Revised 3/2026

Overnight Field Trip Form - Optional page 2

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:		

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Medications continued from page 1 :

Medication (s)	Dose	Frequency	Diagnosis/Purpose

Physician's **STAMP (required):**	Signature:	Date:
Parent/Guardian Name:	Signature:	Date:

Developed 3/2026