



**Bethany School**

**Overnight Field Trip Form for Health**

\*\*\* A SEPARATE DOCTOR'S WRITTEN ORDER MUST ACCOMPANY EACH PRESCRIPTION MEDICATION \*\*\*

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Parent Name \_\_\_\_\_ Phone Number \_\_\_\_\_

1. Does your child have any health issues or needs which may need consideration while on this trip? If yes, explain: \_\_\_\_\_

2. My child will be bringing the following Medication(s): **ALL MEDICATIONS (including Tylenol, Advil, etc.) MUST BE IN THE ORIGINAL CONTAINER. Each prescription will need to be accompanied by a separate administration of medication form signed by a physician. Over the Counter Medication will need to be accompanied by a Non Clinic Stock Over The Counter Form.** \_\_\_\_\_

3. Check any of the following that apply:

My child has:

\_\_\_\_\_ NO Health Problems

\_\_\_\_\_ **SERIOUS** allergy to: \_\_\_\_\_

Treatment for allergy: \_\_\_\_\_

Medication sent: \_\_\_\_\_

\_\_\_\_\_ **ASTHMA**

\_\_\_ My child will be bringing an inhaler with him/her.

\_\_\_ The inhaler medication is \_\_\_\_\_ and should be used as follows:

Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

\_\_\_\_\_ **ADD/ADHD**

My child takes medication and will bring **ONLY THE AMOUNT NEEDED DURING THE TRIP. THE MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION**

**BOTTLE.** The medication is \_\_\_\_\_ as is taken at the

following times: Time: \_\_\_\_\_ Dose: \_\_\_\_\_

Time: \_\_\_\_\_ Dose: \_\_\_\_\_

I understand my child is responsible for any self administered medications (inhaler and EpiPen only) and he/she will NOT share medications with other students. The chaperones will only give the above medications if the student requests it or has a medical need. I take responsibility for this permission and acknowledge the school and its employees or agents shall incur no liability as a result of any injury arising from the administration of medication, and hold harmless the school and its employees or agents against any claims arising out of the student's self-administration or chaperone administration of medication.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date