ARLINGTON CENTRAL SCHOOL DISTRICT
144 Todd Hill Road
LaGrangeville, NY 12540

Health Information for School Trip

Student Name _____ Destination _____

D.O.B. _____ Grade _____ Team/Teacher _____

Yes	No	Check "Yes" or 'No"	
		Has your child been diagnosed with a life threatening allergic condition? If yes*, specify_____ _____ *Students requiring medical treatment for a life threatening allergy require a doctor's order specifying the treatment	
		Does your child have an allergy to medications? If yes, specify: _____ _____	
Yes	No	Does your child have any of the following?	
		Asthma or RAD (Reactive Airway Disease)	
		Bleeding Disorder. Specify:	
		Diabetes	
		Heart Problem. Specify:	
		POTS or History of Passing Out	Date of Last Syncopal Episode:
		Seizure Disorder. Specify type:	Date of last seizure:
		Other conditions. Specify:	
Yes	No	Will your child require any medication for this trip?	
		If yes, please list and provide medication order forms: _____ _____	

I understand that no medication may accompany my child on this trip (including over-the-counter medications such as Tylenol, etc.), without the Medication Order form completed in full and submitted to the school Health Office. All non-emergency medication will be held by a supervising adult.

Legal Guardian _____ Relationship _____
(Signature)

Legal Guardian _____ Date _____
(Print)

Phone #: Home _____ Work _____

Cell _____

Medical Care Provider: _____ Phone # _____

FOR OFFICE USE ONLY

Medication	Order Rec'd	Med Rec'd	As Needed	Daily	Student Carries	Notes