MOUNT SINAI UNION FREE SCHOOL DISTRICT
P.O. BOX 397, NORTH COUNTRY ROAD
MOUNT SINAI, NEW YORK 11766

SCHOOL TRIP HEALTH FORM

THIS FORM MUST BE FILLED OUT COMPLETELY, SIGNED BY A PARENT OR GUARDIAN AND RETURNED TO THE HEALTH OFFICE.

(Please print all information.)

Student's Name: _____ Date of Birth: _____ Grade: _____

Name of Parent/Guardian: _____ Home Phone: _____

Address: _____ Bus. Phone: _____

Parent/Guardian Cell Phone Numbers: _____ _____

Alternate contact in case of emergency:

Name: _____ Relationship to Student: _____

Phone Number: _____ Bus. Phone: _____

Physician's Name: _____ Phone: _____

Medical Insurance Co.: _____ Policy #: _____

My student is allergic to the following: _____

****PARENT AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT****

As parent/legal guardian of _____, I hereby give permission to the Mount Sinai School chaperones to authorize medical treatment by a physician or hospital for my child while on all the school trips.

I understand that every possible attempt will be made to notify me before any treatment is authorized.

_____ _____

Date *Signature of Parent/Guardian*

PLEASE RETURN THIS FORM TO THE NURSE'S OFFICE.

Updated 2/2017