Cincinnati Hills Christian Academy Gr 7-8 Student Health Form- INTERNATIONAL Overnight Trip

This form must be completed and **signed by a parent. If ANY Over the Counter or Prescription Medications are to be administered, then a physician** must sign a separate K-12 School Medication Permission form. Return this form to your School Office. Students may not participate without this completed form on file. Please make a copy of this form for your records before returning it. .

Student Last Name	First	MI	DOB	Grade	Year
_____	_____	_____	___/___/ _____	_____	_____

Phone where Parent can be reached during Over Night Travel: Mother: _____ Father_____

Trip Destination: _____

Parent Health Statement:

I hereby state, to the best of my knowledge, my child, listed here, is in good health and is physically and mentally able to participate in overnight school travel. S/he does not have any injury, illness or disability that will prohibit activity.

Parent's printed name_____ Parent's signature_____

Important Note about Medication Administration on Field Trips: A Physician and Parent signature is required for the Administration of Prescription *and* OTC medication. If your MD has prescribed any of the medications listed below, they will be available on the trip in bulk supply***. Prescribed means that a completed Grade K-12 School Medication Permission form is signed by the physician and the parent and the form is on file in the Nurse's office. If your child requires a medication that is not listed below such as medication that that he/she takes early in the morning, after school or right before bed, then Parents will supply medications in the original bottles with labels and instructions to the building nurse along with an additional Grade K-12 School Medication Permission form that includes the addition of these medication. No medication previously supplied to the school will accompany the student on the trip other than the bulk medications listed below. Students requiring injections must provide all supplies. **IF YOUR CHILD ALREADY HAS A CURRENT SCHOOL MEDICATON PREMISSION FORM ON FILE FOR MEDICATIONS DURING THE SCHOOL DAY AND IT INCLUDES EVERY MEDICATION THAT YOU WISH YOUR CHILD TO RECEIVE ON THIS FIELD TRIP, YOU DO NOT NEED TO SUBMIT AN ADDITIONAL GRADE k-12 SCHOOL MEDICATION PERMISSION FORM. THE NURSE'S WILL COPY THE CURRENT GRADE K-12 MEDICATION PREMISSION FORM FOR USE ON THE FIELD TRIP. IF YOU HAVE QUESTIONS ABOUT WHAT MEDICAL PAPERWORK IS ON FILE, IT IS THE PARENT'S RESPONSIBILITY TO E-MAIIL THE BUILDING NURSE WELL IN ADVANCE OF THE FIELD TRIP TO INQUIRE.**

***Note: Bulk Supply medications include: Acetaminophen (Tylenol), Ibuprofen (Advil/Motrin), Cough Drops (not containing Dextromethorphan), Diphenhydramine Hydrochloride (Benadryl) and Calcium Carbonate (Tums).**

Student Health History (To be completed by a Physician) Please Check all that Apply:

- ☐ Seizures/epilepsy
- ☐ Infection (My child is currently taking antibiotics for this infection ☐ Yes ☐ No)
- ☐ Drug Allergies (list drugs)

_____

- ☐ Food Allergies (list foods)

_____

- ☐ Other Allergies such as Latex or Bee Stings (please list)

_____

- ☐ My child carries an Epi-pen for this allergy ☐ Yes ☐ No
- ☐ My child requires Benadryl to treat minor allergic reactions ☐ Yes ☐ No
- ☐ My child requires an Asthma Inhaler for wheezing, shortness of breath or cough ☐ Yes ☐ No
- ☐ Diabetes (My child has a pump ☐ Yes ☐ No)
- ☐ My child requires daily insulin injections ☐ Yes ☐ No
- ☐ Refrigeration/electricity for medical equipment/medication required ☐ Yes ☐ No If Yes, explain _____
- ☐ Illness, surgery or hospitalization in the last 3 months – ☐ Yes ☐ No If Yes, Reason_____

Physician's Medical Statement:

I understand that the student will possibly be exposed to sanitation issues (i.e. contaminated water, etc.) and will have an active, full schedule daily. Persons with any immunosuppressed or chronic illness may be at risk to their overall health. I have examined* _____on _____. S/he is in good health and is physically and mentally able to participate in this school trip. S/he does not have any injury, illness or disability that will prohibit activity.

MD Name printed:

_____

MD Signature:

MD Phone:_____