

Greece Central School District

Medical Form

Student: _____

DOB: ____/____/____

Field Trip Location: ALL SEASON EVENTS

Field Trip Date(s): ALL SEASON EVENTS

While on the field trip, will your child require medication or any medical treatments?

_____ Yes

_____ No

If yes, describe below:

Does your child have a medical condition of which the teacher should be made aware?
[e.g., diabetes, asthma, seizure disorder, allergies (including bee stings), etc.]

_____ Yes

_____ No

If yes, describe below:

Date of last Tetanus Booster: _____

Family Physician: _____

Physician Phone Number: _____

Insurance: _____ Group #: _____ Medicaid #: _____

Phone: _____ (home) _____ (work) Mother

Phone: _____ (home) _____ (work) Father

Name of Emergency Contact: _____ Phone: _____

In the event of an emergency, I give permission for the supervisor to take my child to a doctor or emergency room. I understand that I will be notified as soon as possible.

Parent Signature: _____

Date: _____