

MOUNT SINAI UNION FREE SCHOOL DISTRICT  
114 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.**