ST. MARY'S An IB World School
www.smaa.org • 7 Pursuit • Aliso Viejo, CA 92656 USA

Field Study Health Form

CHILD'S NAME: _____

The following over the counter medications will be available for us to give your student, if symptoms should arise. **Please check which medications we have your permission to administer to your child,** as per the package directions**:**

_____Ibuprofen (Advil/Motrin) _____Tums (stomach upset)
_____Tylenol _____Cough Drops
_____Benadryl _____Triaminic cold/cough _____Claritin

Children's Bonine for motion sickness: YES_____NO_____ ONLY IF NEEDED_____

If you wish us to provide other medications, please follow these instructions:
Over the counter medications:
In the original container
Labeled by the parent with the child's name
Accompanied by the St. Mary's Over the Counter Medication form and this form
It will be administered according to the manufacturer's directions
Prescription medication:
In the original pharmacy labeled container, labeled with the child's name & physician's name
Labeled with medication name and dose ordered
Accompanied by the Order for Administration of Medication form signed by MD
It will be administered according to physician's directions

By signing this form, I understand that the school is not legally responsible to administer medications to my child and, therefore, I agree to hold the school and its employees free from any and all responsibility and to indemnify each of them against loss by any reason of civil judgment arising out of these arrangements which may be rendered against them.

I, the undersigned, request that a member of the St. Mary's School staff administer the following to my child in accordance with the over the counter and/or physician's instructions. I will notify the school immediately if this medication order is changed.
MEDICATION NAME:
_____
DOSAGE: _____
TIMES OF ADMINISTRATION: AM:_____PM:_____

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DOSAGE: _____
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MEDICATION NAME: _____
DOSAGE: _____
TIMES OF ADMINISTRATION: AM:_____PM:_____

PARENT SIGNATURE _____ **DATE_____**

Field Study Health Form

Student Name_____ Date of birth_____

Home Phone_____ AGE:_____

Mothers Name_____ Cell Phone_____

Work Phone_____

Fathers Name_____ Cell Phone_____

Work Phone_____

IMPORTANT HEALTH INFORMATION (Allergies or health conditions staff should be aware of in parent's absence). PLEASE DOCUMENT ALLERGIES AND ANY HEALTH CONDITIONS

FOOD RESTRICTIONS/FOOD ALLERGIES

ANY OTHER INFO NURSE SHOULD BE AWARE?

_____

INSURANCE INFORMATION

Name of Insurance Company

_____Policy#_____

Address of Insurance Company_____

Phone # of Insurance Company_____

PARENT/GUARDIAN AUTHORIZATION

To the best of my knowledge, the information on this form is correct and complete. The person, herein described, has permission to engage in all field study activities except as noted.-

_____.

I, hereby, give authorization for St. Mary's Staff to provide emergency treatment and administration of medication necessary while on the field study trip including authorization to be treated by a physician in case of an emergency, including hospitalization. I agree to the release of any records necessary for insurance purposes. I give authorization to arrange necessary related transportation for my child.

PARENT SIGNATURE_____**DATE**_____