



St. Gregory the Great Academy

A Ministry of the Church of St. Gregory the Great

Office of the Nurse

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CLASS TRIP MEDICAL FORM

Child's Name _____ Homeroom _____

Destination of Trip _____ Date of Trip _____

Below please list the names of parent/guardian and/or persons to be contacted in the event of an emergency and the telephone or beeper numbers where they can be reached on the above date.

First Contact _____ Work # _____ Home # _____ Cell # _____
Parent/Guardian

Second Contact _____ Home # _____

Third Contact _____ Home # _____

Family Physician _____ Phone # _____

Family Dentist _____ Phone # _____

1. Does your child have any allergies? (e.g., foods, medications, insect sting) _____ Yes _____ No
List allergies _____

2. Is your child currently on any medication? _____ Yes _____ No
If yes, please list the medications including dosage and specific instructions:

3. Is it necessary for your child to take medication on this trip? _____ Yes _____ No
List: _____

4. Does your child have a serious health concern? _____ Yes _____ No
List: _____

5. Your child has the medication _____ available for his/her use as needed at school. This medication and the instructions for its use will be carried and administered by _____ on the field trip if needed.

I have read the information and give my child permission to attend the field trip.

Signature _____ Date _____