FIELD TRIP MEDICATION FORM – OVERNIGHT/AFTER HOURS

Student Name: _____ Date of Birth: _____

Name of Medication: _____ Dose: _____

Time to be given: _____ **OR** As needed every ____ hours

Reason medication is prescribed: _____

Licensed Healthcare Provider Signature: _____ Date: _____

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Parent/Guardian Permission

I hereby give permission for my child, _____ to receive medication as listed above during the school-sponsored trip. As the parent/guardian, I assume responsibility of any adverse reactions this medicine may cause for my child. I agree to send the prescribed medication in a container properly labeled by a pharmacist. Nonprescription medicine will be sent in the original container with child's name written on container.

I give permission for the school and my child's healthcare provider to communicate and share any needed forms by fax. I understand the school cannot guarantee the confidentiality of the fax machine.

_____

Signature of Parent/Guardian Date

_____

Home telephone number Emergency telephone number

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For School Use Only:

Amount of medication received: _____ Signature of person receiving medication: _____
Signature of witness: _____

Date					
Time given					
Initials					

_____ _____ _____ _____

Initials Signature Initials Signature

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