



Authorization for Chaperones to Administer Medication on a Field Trip Prescription or Over-the-Counter

Student Name _____ Date of Birth _____ Grade _____

Field Trip _____ Date(s) _____

Students in grades K-6 may **not** self-administer medication.

My son/daughter needs **prescribed** medication: Yes No

Please list **prescription** medication with instructions and possible side effects (**must** also complete page 2 of this form – see reverse): _____

My son/daughter needs **over-the-counter** medication: Yes No

Please list **over-the-counter** medication with instructions and possible side effects (**must** also complete page 2 of this form – see reverse): _____

Approval of Parent/Guardian and Limitation of Liability

I/We hereby authorize The Bear Creek School personnel to administer the medication identified above to be taken on a field trip as ordered by my child's/ward's physician/dentist or at my direction. I/We understand that my signature on this form constitutes a waiver of liability by me/us to The Bear Creek School and authorized personnel, as may arise from the administration of medication on a field trip. I/We request that authorized personnel administer medications to my child/ward as described above. All medication must be unexpired, in the original container, and label must include my child's/ward's name, name of the medication, dosage and dosing schedule, mode of administration, and name of physician.

I/We hereby acknowledge that I/we read and understand English and have read and understand the terms and conditions set forth in this waiver and authorization form. Alternatively, I/we hereby acknowledge that if I/we do not read and understand English that I/we have consulted with someone who does and such person has fully explained the terms and conditions set forth in this waiver and authorization form. I/We fully understand the terms and conditions set forth in this waiver and authorization form.

Parent/Guardian Signature _____ Date _____

Print Name _____

Parent/Guardian Signature _____ Date _____

Print Name _____

Student Name _____ Date of Birth _____ Grade _____

Oral Medications

Pursuant to RCW 28.A.210.260 and RCW 28A.210.270, The Bear Creek School is authorized to administer oral medication to students during school hours. Such medications will only be administered when the failure to receive the medication may result in the student being unable to attend school and/or not being well enough to participate in learning activities. Medication is defined as all drugs, whether **prescription** or **over-the-counter**.

The administration of any oral medication to a student must be requested and authorized in writing by a parent or legal guardian and a licensed health care provider with prescribing authority acting within the scope of his/her license. Specific instructions for administration must be included.

Requests for the administration of oral medication are valid only for the medication listed and the dates indicated in writing on the request form, and in no case will such requests exceed one school year. Any request for administration during a subsequent school year shall require the request to be re-authorized.

Non-Oral Medications

Medication administered by routes other than oral, for example: ointments, eye drops, nasal inhalers, suppositories, or non-emergency injections, may not be administered by school staff other than registered nurses. Epinephrine is the only injectable medication that school staff are trained to administer to a student who has a predetermined, life-endangering allergy.

This portion to be completed by the Licensed Health Care Provider

Name of Medication	Dosage	Time of Day to be Taken

List any known medication allergies _____

Diagnosis or reason for medication: _____

If given PRN, specify the length of time between doses: _____

Possible side effect of medication: _____

I request/authorize the school to administer the above medication to the above student in accordance with the instructions indicated above for the period from _____ to _____ (not to exceed current school year).

Special instructions _____

Duration of order if less than current school year _____

Licensed Health Care Provider/Physician/Dentist Signature _____ Date _____

Print Name _____ Phone _____ Fax _____

Physician Address _____

Note to Parents

All medication to be administered by school staff must be:

- Brought to school by the parent;
- In the original container, labeled with the student's name, name of the medication, dosage, mode of administration, and name of the health care provider;
- Not more than a one-month supply (unless it is an emergency medication, such as epinephrine or inhaler).