Regional School District #18

Field Trip Medication Authorization Form

Name of Student:_____Date of Birth(mm/dd/yy)__/__/__
Address: _____
Dates of Medication Administration: From _____to_____

Physician Authorization for Administration of the following medications:

Analgesic: for relief of pain/fever: Medication:_____Dose:_____Route:___Time of Administration:_____

Antibiotic: Medication:_____Dose:_____Route:___Time of Administration:_____
Condition for which medication is being administered:_____

Antihistamine: Medication:_____Dose:_____ Route:_____Time of Administration:_____
Condition for which medication is being administered:_____

Antiemetic for relief of motion sickness: Medication:_____Dose:____Route:____Time of Administration:_____

Other: Medication:_____Dose:_____Route:_____Time of Administration:_____
Condition for which medication is being administered:_____
Other: Medication:_____ Dose:_____Route:_____Time of Administration:_____
Condition for which medication is being administered:_____
Other: Medication:_____Dose:_____ Route:_____Time of Administration:_____
Condition for which medication is being administered:_____

Prescriber's Name/Title:_____ Telephone: (___) ___-_____ FAX: (___) ___-_____
Prescriber's Signature: _____ Date: (mm/dd/yyyy): __/__/_____

Parent/Guardian Authorization

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with enough of a supply for the field trip. I understand that I must supply the medication in the original container with a label containing my child's name, name of the medication, and dosage. I understand that any remaining medication must be picked up within one week following termination of the order, or the last day of school, whichever comes first.
Parent/Guardian Signature: _____ Date: (mm/dd/yyyy): __/__/____
Home Phone Number: (___) ___-_____ Alternate Phone Number: (___) ___-____

Self-Administration of Medication Authorization/Approval

Self administration of medication may be authorized by the physician and parent/guardian and must be approved by the nurse in accordance with Regional School District #18 Board of Education policy. Asthma
inhalant medications and Epipens may be approved for middle and high school students. In addition, non-controlled medications for **high school field trips** may be approved for self-administration.

Physician authorization for self-administration: ___Yes ___No _____
Signature and date

Parent/Guardian authorization for self- administration: ___Yes ___No _____
Signature and date

School Nurse approval for self-administration: ___Yes ___No _____
Signature and date