Regional School District #15 Permission to Administer Medications on Field Trips

PARENTS/GUARDIANS MUST CALL THE SCHOOL NURSE ABOUT ALL MEDICATIONS GOING ON FIELD TRIPS AT LEAST 1 WEEK BEFORE TRIP DEPARTS.

THIS SECTION COMPLETED BY PARENT/GUARDIAN	MPLETED BY	PARE!	NT/GUARD	IAN STATES		TRIP DESTINATION:	IATION:	o o to	
I request that my child receive the medications listed on the form as ordered by my physician. I understand that I must send medication on the field trip in the original container dispensed and properly labeled by a physician or pharmacist. I agree that any controlled medication such as Ritalin, Codeine, Dexedrine, etc. will be brought to the school by me or an adult that I designate. I understand that arrangements must be made through the Nurse's Office for controlled medications to be administered on the trip as these cannot be self administered by my child.	properly labeled properly labeled me or an adult the as these cannot	ations lis I by a ph nat I des be self a	sted on the to sysician or ph signate. I und administered	rm as order larmacist. I lerstand tha by my child.	ed by my physician. I agree that any contro t arrangements must	understand that I m lled medication such be made through the	ust send medication as Ritalin, Codeing Nurse's Office for	n on the field tri e, Dexedrine, e controlled med	p in the originate. will be ications to be
Student's Name (print)				Grade	Date	Home Phone	Cell Phone		Work Phone
Allergies									
Parent/Guardian's Name (print)	ne (print)			Paren	Parent/Guardian's Signature	ıre	Relat	Relationship to Student	dent
THIS SECTION COMPLETED BY PHYSICIAN - complete all sections for both over the counter & prescription medications	NPLETED BY	<u>PHYSI</u>	<u>CIAN</u> - com _l	olete all sec	tions for both over	lhe counter & preso	unter & prescription medications	ns	
Patient's Name (print)				Date					
Medication & A How Dispensed G	Amount to be Given	Route	Frequency	PRN (check)	Dates of Trip (from-to)	OK to Self Administer?	Reason for Medication	Side Effects	Controlled Drug?
Physician's/Dentist's Name (print)	lame (print)		Phy	/sician's/De	Physician's/Dentist's Signature		Phone		
Address			City	Citv. State			Zip Code		

Medication Administration Record

Student's Name	lame		Field Trip – TO:	р – TO:	FROM:	ť
					(destination)	(dates)
NAME OF F	NAME OF PERSON(S) Administering Meds (print)	y Meds nt)		(S)	(signature)	(initials)
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2.						
<u>ယ</u> 						
Date	Name of Medication	Dose Given	Time Given	Initials of Person Giving Medication	Comments	

BEFORE ANY MEDICATION IS ADMINISTERED FOR THE FIRST TIME THE FOLLOWING ITEMS MUST BE IN PLACE:

The authorization form is completed
The original prescription label is on the medication container
The name of the child is on the container

The date on the prescription is current (prior to the expiration date on the label.