LEGACY EARLY COLLEGE
Elementary through College

"to and through college"

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PARENTAL PERMISSION FOR MEDICATION FOR OVERNIGHT FIELD TRIP

Each medication to be given must have a Field Trip Parental Permission paper completed, one medicine, one form. Students may not have medications in their possession.

This form and the medication must be given to the school nurse or directly to the person administering medication on the trip at least three (3) days before the trip. Only the amount of medication needed on the trip should be sent.

A physicians' written authorization is required for all prescription medication. Parent authorization is required for all non-prescription medications. If the medication currently is administered at school and has the paperwork completed the parent may complete the form below and return. If the medication is currently given at home and not at school please have correct form completed (prescription/ non-prescription) and return with this form for the field trip.

Student's Name:_____ Teacher:_____

Destination:_____ Date(s) of the trip:_____

ALLERGIES: _____

Medication and purpose	Route	Dosage	Time(s) to be given per day

I understand that all medication will be provided by me in the original containers, clearly marked with my child's name and given directly to the school nurse or the person in charge of medication administration on this trip. Permission is granted to share the information with other individuals who will have direct responsibility for my child. All **first dose** will be given at home so that I can monitor reactions.

_____ _____

SIGNATURE OF PARENT DATE

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FIELD TRIP MEDICATION RECORD

For school use during the trip by staff

Student's Name:	Date of Birth: Grade:

Medication:	Times to be given:	Dosage & Route:

Allergies:	Date/Time/Initials of person transcribing order:
Starting Medication Count=_____ (Controlled substances must be counted by two school employees. The person who will be responsible for the medication on the fieldtrip should be one of the persons involved in the count. The school nurse should be involved in the count)	DATE: _____ Initials of Counter: _____ Initials of Witness: _____

DATE	Dosage	Times given	Initials

**********	**********
Signature of person (s) administering medication with title	Initials
1.	
2.	