BEAUFORT COUNTY SCHOOL DISTRICT
HEALTHCARE PROVIDER'S ORDER FOR MEDICATION DURING STUDENT TRAVEL

Parents: If your child has a medical condition or is on regularly prescribed medication, please have your healthcare provider complete this form. This completed form must be submitted to the field trip supervisor , before the student will be allowed to participate.

Dear Healthcare provider:

This child will be participating in an approved field trip to ___________________from ______________________to ______________________. There will not be a nurse in attendance on this trip. Please indicate below any prescription and/or over-the-counter medications that your patient is currently taking and will need to continue to take while on this trip.

____ _________________________

Student's name Date of birth

To be completed by the physician

Medications/Treatments	Dosage/Frequency of administration	Circumstances/Symptoms for administrations	Diagnosis

____ _________________________

Signed by prescribing healthcare provider Date

____ _________________________

Signature of parent/legal guardian Date

To be completed by designated school personnel

Medication/Treatment	Date/Time	Date/Time	Date/Time	Signature of designated school personnel

Distrito Escolar del Condado de Beaufort

**ORDEN DE MEDICAMENTOS PARA LOS ESTUDIANTES
HACIENDO VIAJE ESCOLAR
POR EL PROVEEDOR MEDICO**

Padres: S i su hijo tiene una condición médica o está tomando medicamentos recetados regularmente, por favor llevar este formulario a su proveedor de atención de salud para completar. Este formulario debe ser completado, firmado y presentado al supervisor del viaje o excursion, antes que el estudiante se le permitirá participar.

Mi hijo/ alumno va a participar en un viaje de estudio a ______________________________ del dia ______________________________hasta el dia ____.

No habrá una enfermera en asistencia en este viaje. Por favor, indique a continuación, cualquier prescripción y / o medicamentos de venta libre que su paciente está tomando actualmente y cuales tendrá que seguir tomando, mientras que en este viaje.

(This child will be attending a school field trip on the dates identified above. No medical personnel will be on the trip with the student. If there are medications, prescribed or over-the counter, that the student needs to continue to take while on the trip, please complete the chart below.)

____ __________________________
Nombre del estudiante (student name) Fecha de nacimiento (DOB)

To be completed by the physician (para ser completado por el medico)

Medications/Treatments	Dosage/Frequency of administration	Circumstances/Symptoms for administrations	Diagnosis

____ __________________________
Signed by prescribing healthcare provider Date

____ __________________________
Signature of parent/legal guardian Date

Para ser completado por personal de la escuela: ***(To be completed by designated school personnel)***

Medication/Treatment	Date/Time	Date/Time	Date/Time	Signature of designated school personnel