PERMISSION FORM FOR PRESCRIBED OR OVER-THE-COUNTER MEDICATION

In some situations, students may be authorized to self-administer their own medication while on school-sponsored trips. A school employee will be responsible for keeping the medication in a safe and secure place while on a field trip until such time that the student requires the medication. At the appropriate time, the medication will be available to the student to self-administer in the presence of the school employee**.**

THE MEDICATION MUST BE IN THE ORIGINAL CONTAINER WITH A VALID EXPIRATION DATE. IF THE MEDICATION IS PRESCRIBED BY YOUR HEALTHCARE PROVIDER, THE ORIGINAL PRESCRIPTION LABEL MUST BE ATTACHED.

If your student requires medication during the field trip, please complete the following:

School: ____Date form received by the School: _____________

Student's Name: ________________________________ **Grade:** ______ **Homeroom/Classroom:** ___________

Student's Age: ________ **Date of Birth:** ________________________

TO BE COMPLETED **BY THE PHYSICIAN OR HEALTH CARE PROVIDER** FOR **PRESCRIPTION MEDICATION**

Name of medication: _________________________ Reason for medication: _____________________________

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _________

Describe schedule and dose to be given at school: ____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other __________________________

Student is capable of/responsible for self-administering this medication: ☐No ☐Yes ☐Supervised ☐Unsupervised

Student has been instructed in self-administering the medication: ☐No ☐Yes

Student must carry this medication on his/her person (inhaler, Epi-pen, Glucagon only): ☐No ☐Yes

Please indicate additional information: ☐ On the back side of this form ☐ As an attachment

____ ____________
Physician/Health Care Provider Signature ***Date***

____ ____________
Signature of Parent/Guardian ***Date***

Name of Physician/Health Care Provider: ____

Address: ____

Phone #: ________________________ **Fax #:** _________________________

To the school: Please report concerns about medications or the student's condition to the above physician/health care provider.

PERMISSION FORM FOR PRESCRIBED OR OVER-THE-COUNTER MEDICATION

TO BE COMPLETED **BY PARENT/GUARDIAN**
FOR **NON-PRESCRIPTION MEDICATIONS**

As the parent or legal guardian of the student named below, I authorize my child to take the following over-the-counter medication as noted:

Name of Medication: ____

Dosage/Schedule: ____

Other Information: ____

TO BE COMPLETED BY ALL PARENTS/GUARDIANS

I give permission for ________________________________ to receive the above medication(s) at school according
Student's Name
to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication, **any adverse effects or side effects, or a student's refusal to take or administer the medication,** unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed. **By signing below, I acknowledge that the school employee is NOT responsible for administering the medication. My child has been instructed on the use and necessity of this medication and he/she is capable of administering the medication independently.**

Date: ______________ *Signature:* __________________________________ *Relationship:* _____________

Home Phone: ________________ *Work Phone* ____________________ *Emergency Phone* ________________

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing statement and authorization.

Administrator/designee ____ Date __________________________