Medication Authorization for Overnight District Trips

Staff Member in charge of trip: _____

Dates of trip: _____

Student's Name: _____

Date of Birth_____ Student ID number _____

Parent/Guardian Name: _____

Parent/Guardian Phone Number : _____

Parent/Guardian Signature : _____ Date: _____

Choose ONE of the options to indicate the medication requirements for your student while participating in district sponsored activities.

Option 1 : My student **does not** require any medication during this trip/activity, and/or parent will be available during the trip/activity to manage the medication(s.)

Parent Initial _____ (Form is complete, please turn in form.)

OR

Option 2: I am requesting that my student be able to **self-carry and self-administer** their own medications for this trip/activity (Form is INCOMPLETE until backside is completed and signed by parent, student, and provider.)

Parent Initial _____

OR

Option 3: I am requesting that a **staff member be in charge of carrying and administering** my student's medication (s) during the trip/activity.

Parent Initial _____ (Form is INCOMPLETE until backside is completed and signed by provider.)

FOR ALL MEDICATIONS, PRESCRIPTION AND OVER-THE-COUNTER, SELF-CARRY OR STAFF CARRY, BACKSIDE OF FORM NEEDS TO BE FILLED OUT

Questions about the form, please contact Lauren Hale, MSN, RN at (937) 439-3505 or lauren.hale@centerville.k12.oh.us.

Student's Name _____ Date of Birth _____ ID Number _____

FOR SELF-CARRY MEDICATIONS:

I am requesting that my student be able to self-carry and self-administer the medication(s) for this trip/activity. My student has been instructed on the medication, its purpose, its recommended dosage, and my student feels comfortable in self-administering. My student is solely responsible for the medication(s) and will never share or let other students use their medication(s). My student will report any adverse side effects to a staff member promptly, as well as let the staff member in charge know if the medication(s) were taken in error or if the dosage(s) were incorrect. As the parent, I will provide the medication(s) in the original container(s). If the medication(s) is/are prescribed by a provider, all will come in the pharmacy container(s) with the correct pharmacy label(s). I will notify the school of any changes to the medication(s) and will have the provider change the orders as necessary to reflect the new medication, dose, route to be given, time to be given, etc…. I understand that staff can revoke the right for student to self-administer medication(s) at any time if the staff member feels the student is being unsafe or is violating any of the procedural safe guards in place.

Parent/Guardian Signature _____ Date_____

Student Signature _____ Date _____

Please list all medication(s), both self-carry and staff carry, prescription, and over the counter, that will be on the trip:

Medication Name:_____ Dose: _____ Time: _____

Medication Name:_____ Dose: _____ Time: _____

Medication Name:_____ Dose: _____ Time: _____

Medication Name:_____ Dose: _____ Time: _____

Medication Name:_____ Dose: _____ Time: _____

Medication Name:_____ Dose: _____ Time: _____

Medication Name :_____ Dose: _____ Time: _____

Medication Name:_____ Dose: _____ Time: _____

FOR ALL MEDICATIONS:

As the prescriber, I have determined that either this student is capable of possessing and self-administering the above listed medication(s) for this trip activity, or for staff carry medication(s), I authorize staff of Centerville City School District to carry and administer the medication (s) for the above named student.

Provider Name _____ Phone Number: _____

Provider Signature: _____ Date: _____