Shorewood High School Health Office

PERMISSION TO ADMINISTER MEDICATION FOR EXTENDED FIELD TRIPS

Shorewood
17300 Fremont Avenue North
Shoreline, Wash. 98133
FAX – 206-393-4711
Phone – (206) 393-4386
Attn: School Nurse

Student _____

Birth Date _____ Age_____Grade_____

Parent(s) Guardian(s)_____

Night Phone_____Day/Phone_____

PHYSICIAN'S ORDERS FOR MEDICATIONS FOR EXTENDED FIELD TRIPS

This INCLUDES over-the-counter medications. Please list the **24 hour medication needs** for daily as well as medications the student may take on an "as -needed" basis.(Tylenol, Imodium, Dramamine, Midol etc.)

☐ Student may carry and self-administer medications as listed below

Medication	Dosage	Admin. method	Time (hour) to be given

Camp start medication_____Camp discontinue medication_____

This medication is being prescribed for the following reason(s) _____

Possible side effects_____

Other comments_____

➡ _____
Signature of Licensed Health Care Provider Date Phone

_____
Printed Name of LHP

PARENT/GUARDIAN REQUEST FOR MEDICATION ADMINISTRATION FOR EXTENDED FIELD TRIP:

☐ **I give my permission for this student to carry and self-administer the medication(s)**.
If you would prefer a Shorewood staff member carry and administer the medications, please write in that request. _____

I accept responsibility for supplying in the original container (prescription bottle or over-the-counter container), and for immediately notifying the school nurse of any change in these instructions.

I give my consent for the confidential information contained on this form to be FAXed to the above named school.

I understand that my signature on this form constitutes a waiver by me of liability on the part of Shorewood or staff member for untoward reactions when the medication is administered in accordance with the above directions.

➡ _____ _____
Signature of Parent/Guardian **Date**