Pearland Independent School District

Authorization for Sponsor Administration of Medication on Overnight Trips

Overnight Trip Date: ____Overnight Trip Sponsor/ Group: _____Overnight Trip Destination:_____

If there is not already a medication authorization form on file in the clinic, with instructions that match the medication administration request being made, the student's parent or legal guardian will need to complete this form for the student to receive medication (prescription or over-the-counter) from a Pearland ISD staff sponsor during the overnight trip. **EXPIRED OR INCORRECTLY LABELED MEDICATION WILL NOT BE ACCEPTED.** Instructions for administration of over the counter medication must comply with the directions for administration on original packaging. Prescription medicine must have a U.S. pharmacy prescription label with administration instructions matching those on the medication authorization form. **No narcotics will be administered. Medication must be in its original container. All medications for this trip must be turned in to the school clinic, along with this completed form, three days prior to departure.**

Permission to Administer Prescription or Non-Prescription Medication

Student Name (Last) (First) (MI)	DOB
Grade	Teacher

Type of Medication ☐ Prescription ☐ Non-Prescription	Name of Medication		
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given
Reason medication is being given			
Route of Administration ☐ Oral ☐ Inhalation ☐ Topical ☐ IM ☐ SQ ☐ Other:			
Prescribing Health Care Provider Name	Prescribing HealthCare Provider Signature	Office Phone	Date

I give permission for the sponsor to administer these medications to my child as directed above.

If a student is found to be carrying medication without the appropriate authorization on file or is found sharing medication, then the student will be considered to be in violation of the district's drug-free policy and will be referred to a campus administrator for violation of student code of conduct.

Signature of Parent/Guardian: _____ Date: _____

Signature of Prescribing Health Care Provider: _____ Date: _____
(Required ONLY for trips of 10 days or more)