



Field Trip Travel Permission
And Medical Information

Staff Use Only:
Allergies:
Asthma Inhaler:
Epi Pen:

Campus:
Org.
Academic Year:

Student Name: (Last, First) Age: Male/Female (Circle One)
Date of Birth: Grade:

Parent/Guardian:

Name(s):

E-mail:

Full Address:

Phone Number(s): Please list all where you can be reached...

Phone Number(s): H( ) Wk( ) Cell( )

Emergency Contact: (Other than parent/guardian.)

Name: Relationship:

Full Address:

Phone Number(s): H( ) Wk( ) Cell( )

Medical Information:

Doctor's Name: Phone Number: ( )

Health Insurance Carrier:

Policy Holder Name: Policy #:

Physical History:

List special medical problems: (asthma, diabetes, allergies/anaphylaxis, seizures etc.):

List any known allergies to food / medications etc:

Does participant carry medications on person?(if so please state):

Does your child have a medical condition which requires prescription medication to accompany and possibly be administered, on school sponsored trips? Yes / No

If yes, please complete the Prescription Medication Authorization Form.

Permission:

In the event of an injury/illness requiring medical attention, I hereby grant permission to the supervising teacher and/or staff (including volunteers/chaperones), to attend to my son/daughter. If the injury/illness requires further medical attention, I expect every effort will be made to contact me to receive my specific authorization before action is taken. If efforts to contact me are unsuccessful, I grant permission for further necessary medical treatment to be given. In addition, I also give my permission for the supervising teacher and/or staff (including volunteers/chaperones), to transport my child to the physician, dentist, clinic, or to the hospital if an accident or serious illness occurs on the trip and I cannot be located. I understand that treatment will not be delayed in the event I cannot be contacted. I understand and agree that I, and/or my child's other parent(s)/legal guardian(s), am responsible for all medical expenses incurred in treating my child.

Signature of Parent

Date



Student Name: \_\_\_\_\_

(Last, First)

### ***Non-Prescriptions/Over-the-counter (OTC) Medication Authorization:***

I give Pflugerville ISD representatives, including staff and volunteer chaperones, permission to administer "over-the-counter" medications including, but not limited to, the following medications, at the request of my child. I understand that PflISD personnel will not administer medications if this form is not complete.

\_\_\_\_\_ I **DO NOT** give consent to staff to administer any non-prescription medication to my student.

\_\_\_\_\_ I **DO** give consent to staff to administer non-prescription medications to my student as initialed below:

**Please initial all approved medications that can be administered:**

\_\_\_\_\_ Ibuprofen

\_\_\_\_\_ Acetaminophen

\_\_\_\_\_ Antihistamine

\_\_\_\_\_ Anti-Diarrheal

\_\_\_\_\_ Antacids

\_\_\_\_\_ Cough Drops

\_\_\_\_\_ Antibiotic Ointment (topical for cuts and/or scrapes)

\_\_\_\_\_ Hydrocortisone Cream (for topical  
itch/rash relief)

***Is your child allergic to topical antibiotic ointments? Yes/No***

***"Over-the-counter" medication NOT to be given to my child include:*** \_\_\_\_\_

***Parent Signature:*** \_\_\_\_\_

***Date:*** \_\_\_\_\_



Student Name: \_\_\_\_\_  
(Last, First)

### Prescription Medication Authorization:

I request that a PfISD representative, including staff and volunteer chaperones, administer the following medication to my child according to the physician's instructions while on this field trip. I agree to furnish an adequate amount of medication in the original container at the time of travel. **All medications must be in their properly labeled containers with name, dose, frequency of administration clearly noted.** Students may only self administer inhalers and epi-pens with the appropriate forms on file with the district, and must be signed by a their physician and prescription labels must be current. As needed (or PRN) medications should have the frequency of repeat doses indicated on the orders. **Expired medications cannot be given. A second labeled container can be obtained by asking your pharmacist.** Attach another sheet of paper if necessary to continue with medications. **The first dose of any new prescription medication must be given at home.**

#### Medications

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Parent notified: \_\_\_\_\_

Reportable side effects: \_\_\_\_\_

Date

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Time/Initial

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Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Parent notified: \_\_\_\_\_

Reportable side effects: \_\_\_\_\_

Date

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Time/Initial

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Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Parent notified: \_\_\_\_\_

Reportable side effects: \_\_\_\_\_

Date

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Time/Initial

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# Medications (cont.)

Student Name: \_\_\_\_\_  
(Last, First)

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Parent notified: \_\_\_\_\_

Reportable side effects: \_\_\_\_\_

Date														
Time/Initial														

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Parent notified: \_\_\_\_\_

Reportable side effects: \_\_\_\_\_

Date														
Time/Initial														

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Parent notified: \_\_\_\_\_

Reportable side effects: \_\_\_\_\_

Date														
Time/Initial														

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Parent notified: \_\_\_\_\_

Reportable side effects: \_\_\_\_\_

Date														
Time/Initial														

\_\_\_\_\_  
Admin. Signature /Initials