FIELD TRIP MEDICATION CONSENT FORM

_____has my consent to receive the following medications:
Student's Name (last, first)

AT THE NURSE'S DISCRETION STUDENT MAY TAKE: (Circle appropriately)

Acetaminophen 325 mg. Yes No Tablets: One Two
(Non-aspirin or Tylenol) (Circle) (Circle)

List any medications which will need to accompany the student on the field trip and the dosage and time to be given.

***IF POSSIBLE, PLEASE GET MEDICINES TO THE NURSE BY WED, APRIL 29, 2025**

OFFICE USE ONLY

5/6 5/7 5/8

Medication_____Dosage_____Time_____
Prescription # _____
Reason for medication_____

Medication_____Dosage_____Time_____
Prescription # _____
Reason for medication_____

Medication_____Dosage_____Time_____
Prescription # _____
Reason for medication_____

Medication_____Dosage_____Time_____
Prescription # _____
Reason for medication_____

SPECIAL INSTRUCTIONS: _____

Medications must be furnished by parent. If it is a prescription, it must be in its **ORIGINAL PHARMACY BOTTLE, LABELED** with Child's name, prescription number, and identification of medicine. **Over-the-counter** medicines must also be **in their original containers** with labels intact to identify. The school district personnel will not be responsible or liable for any reaction to medicines given according to the above direction. All medications will be kept in a secured container to be administered by the school nurse, teacher, or field trip leader.

_____ _____
DATE **SIGNATURE OF PARENTS OR GUARDIAN FOR MEDICATIONS**

THIS FORM MUST BE RETURNED TO SCHOOL NURSE PRIOR TO THE DAY OF THE FIELD TRIP.