



Pearland Independent School District

Authorization for Sponsor Administration of Medication on Overnight Trips

Overnight Trip Sponsor/Group: _____ School Year: _____

This form is valid for one school year.

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 **and** physician 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.** Over the counter medication must be in its original container. Prescription medicine must have a U.S. pharmacy prescription label with administration instructions matching those on the medication authorization form. **A Sponsor must administer controlled substances (i.e., ADHD medication). No narcotics will be administered. All medications for this trip must be turned in to the school clinic, along with this completed form, three (3) days prior to departure.**

Permission to Administer Prescription or Non-Prescription Medication

Student Name (Last)		(First)		(MI)	DOB
Grade		Teacher			
Type of Medication <input type="checkbox"/> Prescription <input type="checkbox"/> 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 <input type="checkbox"/> Oral <input type="checkbox"/> Inhalation <input type="checkbox"/> Topical <input type="checkbox"/> IM <input type="checkbox"/> SQ <input type="checkbox"/> Other:					
Prescribing Health Care Provider Name		Prescribing HealthCare Provider Signature		Office Phone	Date

I give permission for the sponsor to administer this medication 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 Sponsor: _____ Date: _____

Signature of Sponsor: _____ Date: _____

ONLY ONE MEDICATION PER FORM – ALL BOXES MUST BE COMPLETED