



Overnight Field Trip **Medication Administration Authorization**

School Year: _____

Student Name: _____ DOB: _____

Parent/Guardian Name: _____ Contact #: _____

<u>Medication Name</u> <u>Dose - mg <i>and</i> amount</u> (i.e. 1 tab, 2 tsp) <u>Route</u> (i.e. by mouth, inhaler, injection)	Morning	Lunch	Dinner	Bedtime	As Needed (frequency)	Notes: (side effects, special instructions, storage, etc) ☐ Check box if student can self administer and self carry medication (controlled substances ie: stimulants, are excluded from self carry)
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						☐
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Michigan Law requires written orders from the treating physician/licensed prescriber and written authorization from the parent/guardian in order for school staff to administer medications to students in the school setting.

**** The signatures below signify that the above medication is the current and correct (prescribed and over the counter) medication regimen (including dose and schedule) for the above named student.**

I hereby authorize trained school staff to administer the above medication, ordered by the licensed provider, to the child named above. I will not hold the Board of Education or its personnel responsible for complications related to medication pursuant to P.A.451 of 1976-S1178.

Physician Name: _____ Phone #: _____

Address: _____

****Physician's Signature:** _____ **Date:** _____

****Parent's Signature:** _____ **Date:** _____

Please send **enough medication for the length of the field trip *only*** in the **ORIGINAL** prescription bottle with the label intact.

Additional Field trips: Date: _____ Signature: _____ Date: _____ Signature: _____