Medical Permission and Release Form
Field Trips

Student's Name: _____ Grade: _____

Over-the-Counter (Non-Prescription) Medication Permission

___ My child/guardianship does not have the permission to take any medication on this trip.

___ I hereby authorize my child/guardianship to receive the following over-the-counter medications checked below.
((Stock Tylenol 325mg tab, Benadryl 25mg tab, and Ibuprofen 200mg tab will be available on the trip. If your child requires another formulary, or another OTC medication, please deliver a supply to the school nurse labeled in the original container, to be held by the chaperone for the duration of the school-sponsored trip)

___Tylenol (Acetaminophen) ___Advil/Motrin (Ibuprofen) ___ Benadryl

___ Other: _____

Prescription Medication Permission

Please fill out the sheet on the back of this form for the daily medication(s) that your child will be taking during this trip. **The medication MUST be in the original container labeled with physician's prescription.**

___ I hereby authorize my child/guardianship to take prescribed medications they take on a daily basis during this trip. (I am aware that the medication must be in the original container labeled with the doctor's prescription.)

___ My child/guardianship may need their inhaler during the trip (I will provide the medication and a physician's prescription if there is not one on file with the health office.)

___ My child/guardianship may need their Epi-pen during the trip for allergies to: _____
(I will provide the medication and a physician's prescription if there is not one on file with the health office.)

I am aware that no medication(s) will be given if they are not in their original labeled container.

_____ _____
Parent/Guardian Signature Date

Daily Prescription Medication Administration on Field Trips

My child/guardianship will need the following medication(s) during this school-sponsored field trip. I am aware that a chaperone will hold the medication for them and will make it available only at the designated times listed below.

Medication Name: _____

Dosage: _____

Time(s) to be given: _____

Special instructions: _____

Medication Name: _____

Dosage: _____

Time(s) to be given: _____

Special instructions: _____

Medication Name: _____

Dosage: _____

Time(s) to be given: _____

Special instructions: _____

I am aware that no medication(s) will be given if they are not in their original labeled container.

_____ _____

Parent/Guardian Signature Date