PARENT'S REQUEST FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL FIELD TRIP AUTHORIZATION

All medication administered by school personnel or supervised volunteer during this field trip/overnight educational experience shall be clearly marked with the student's name, doctor's name, contents and dosage in the original label pharmacy container.

Name of Student: _____ Date of Birth: _____

Parent's/Guardian's Name: _____

Address: _____ Telephone: _____

Teacher: _____ Grade: _____

Physician's Name: _____ Telephone: _____

Condition for which medication is to be given: _____

Name of medication: _____ Prescription Number: _____

Dosage: _____ Time to be given: _____

Name of medication: _____ Prescription Number: _____

Dosage: _____ Time to be given: _____

Special instructions, if any: _____

_____

Special Health Concerns: _____

_____

Medical Insurance Company: _____

Telephone Number: _____ Policy Number: _____

In case of accident or sudden illness to my child, and in the event I cannot be reached by telephone, I hereby authorize a representative of the school district to contact _____. If possible, the parent(s) or guardian will be contacted in the event of an emergency and that permission is hereby granted to the health care professional or accredited hospital to perform any medical and/or surgical procedure that is deemed necessary. The parent or guardian responsible for this student will be responsible for payment of such care.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Home Telephone Number Business Telephone Number

Medication and permission received by: _____

Date received: _____