FIELD TRIP MEDICATION AUTHORIZATION FORM

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Student Name:_____ Date of Birth:_____ Allergies:_____
School:_____ Teacher Name:_____ Field Trip Dates: ____/____/____-____/____/____
Parent/Guardian Name(s):_____ Parent/Guardian Phone Number(s):_____

If you are sending prescription medication, non-prescription medication, vitamins, supplements, etc., for your student then you *must:* ❶indicate the type of medication(s), vitamins, supplements, etc., below; ❷sign where indicated; and ❸obtain your doctor's signature. *IMPORTANT:* You must ensure that all medications are FDA approved for use in this manner, properly labeled, and *in their original containers*. For students to be given these medications BOTH parent AND physician signatures are REQUIRED at the bottom of this form.

SECTION 1: NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION

Over-the-counter medication will NOT be administered without parent and physician signatures. The above named student is approved to take the following medications, as needed, in accordance with the directions on the packaging. Please check "Yes" or "No."

STUDENT AGE:_____ **STUDENT WEIGHT:**_____

Medication	As Needed for	Yes	No	Medication	As Needed for	Yes	No
Ibuprofen (Motrin/Advil)	Pain			Cough Drop/Throat Lozenge	Cough or Sore Throat		
Acetaminophen (Tylenol)	Pain			Decongestant	Stuffy Nose		
Diphenhydramine (Benadryl)	Allergic Reaction/Rash			Antacid	Upset Stomach		
Other:_____				Other:_____			

Comments:_____

SECTION 2: STUDENT RESTRICTIONS

Is there any reason for limiting or accommodating your student's activities? (e.g., injury, Asthma, etc.):_____

Please list any food allergies, dietary restrictions or concerns:_____

SECTION 3: PRESCRIPTION MEDICATION

MEDICATION NAME	DOSE	METHOD (e.g., by mouth, etc.)	TIME(S)	Permission to carry Inhaler, Epi-Pen and/or Glucagon?	
				Yes	No

Possible side effects that need to be reported to the physician (e.g., allergic reaction):_____

SECTION 4: PARENTAL CONSENT AND AUTHORIZATION

I, the undersigned, the parent/guardian of the above named student, request my student be assisted with or administered the medication listed above in accordance with the California Education Code (Education Code 49423).

I will:
1. Provide all prescription medications, supplies and equipment.
2. Notify the school if there is a change in the student's health status or attending physician.
3. Notify the school immediately and provide a new consent for any changes in the doctor's orders.

I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN MEDICATION (i.e., Inhaler, Epi-Pen, and/ or Glucagon) WITH PERMISSION NOTED IN SECTION 3 ABOVE, IT MUST BE ON HIS/HER PERSON AT ALL TIMES DURING THE FIELD TRIP.

I authorize the school to communicate with the Authorized Health Care provider if necessary in regards to the above medication/medical condition.

I hereby authorize a school nurse or trained unlicensed designated school personnel to administer or assist in the administration of the above prescription medications and/or over-the counter medications (as needed).

PARENT/GUARDIAN SIGNATURE:_____ ***DATE:***_____

SECTION 5: PHYSICIAN CONSENT AND AUTHORIZATION

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance to CA state laws and regulations. I understand that a school nurse or trained unlicensed designated school personnel may administer or assist in the administration of the above medication(s). This authorization is valid for one year. If changes are indicated, I will provide new written authorization (may be faxed).

PHYSICIAN SIGNATURE:_____ ***DATE:***_____ ***STAMP:***

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Student Name:_____ School:_____ Teacher Name:_____

SECTION 6: EMERGENCY INFORMATION

MEDICAL TREATMENT

If a serious emergency arises, it might be necessary for a physician to attend to your student before someone can contact you.

In the event of illness or injury, whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed by or under supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services will be given. Further, as a parent or guardian of a student who will be attending this school sponsored trip, I understand that it is not the same physical environment as a traditional school. There may be certain inherent hazards, including natural and man-made conditions at the site which may result in physical injury, harm, damage or death. I understand that there is no warranty or guarantee of my student's safety or security.

I hold the school district, its officers, agents and employees, harmless from any and all liability or claim which may arise out of or in connection with my student's participation in this school sponsored trip and I waive all claims against the school district for injury, accident, illness or death occurring during or by reason of my student's participation (Education Code 35330).

FIRST AID

In the event that your student requires minor first aid, a school sponsored trip Teacher, Chaperone, or Administrator, will render treatment as necessary in accordance with standard first aid practices.

TRANSPORATION

I may be contacted to transport my student home due to illness or misconduct.

FOR SCHOOL USE ONLY

MEDICATION LOG – FOR COMPLETION BY SCHOOL

This is the chart that will be used to log any medication given to your student. It will be returned to school after the trip. When a medication is given, the staff member will write the time and their initials in the chart and will fill out the bottom section.

Medication	Dose	Frequency	Mon			Tues				Wed				Thurs				Fri	

Printed Name	Initials	Signature	Title