SOMERS PUBLIC SCHOOLS

FIELD TRIP MEDICATION PERMISSION

Authorization for the administration of medications by school personnel to a student while on a field trip.

Part A: (to be completed by parent/guardian)

TO SCHOOL PERSONNEL:

I hereby request that the following medication________________________ordered by a physician/dentist for my child ____________________________________be administered by school personnel while on a school sponsored field trip on ____.

THE COMPLETED AUTHORIZATION FORM SIGNED BY THE PHYSICIAN/DENTIST IS ON FILE IN THE STUDENT'S HEALTH RECORD.

Signature Parent/Guardian____Date:______________

Address:____Tel. No.____________

PART B: (to be completed by school nurse)

Individual Student Medication Record
To be used on a Field Trip

Student's Name____

Physician/Dentist ordering medication____Tel. No.____________

Drug Name____________________Strength________________Dosage to be given______________________

Dates to be given____________________________Time to be given___________________________________

Side effects of medication to be observed:____

Part C:

SCHOOL PERSONNEL ADMINISTERING THE MEDICATION MUST COMPLETE THE FOLLOWING

Date Mo /Day /Yr.	Given AM	Given PM	Dose	Legal Signature of Nurse/ Principal/Teacher Administering medication	Comments	Amount of control drug remaining