Fort Cherry School District

**Field Trip/School Event Medication Form**

If it is essential that your child receive prescription and/or over the counter medication during a school sponsored event, you and your healthcare provider must complete this form. This will permit your child to self-administer their own medication during the field trip/event. The completed form and medication, including over the counter medicines, must be given to your child’s school nurse no later than two days prior to the event.

**All medication must be in the original container or package,** **and must be accompanied by this form. No hand written notes or medicines in bags will be accepted. Only send the amount of medication needed for the trip.**

The field trip sponsor or coach will keep all medication in their possession. When your child needs to take the medication, he/she will self-medicate under the sponsor/coach’s supervision.

**Parent/Guardian Consent**

I give my permission for the medication(s) listed below and prescribed by my healthcare provider to be self-administered by my child during the noted school sponsored field trip/event.

In addition, I give permission for my child to self-administer the following over the counter medications: acetaminophen, ibuprofen, and antacids according to manufacturer’s recommendations.

I release the Fort Cherry School District and its personnel from any liability associated with my child’s self-administration of these medications. I understand and agree that any relevant medical information pertaining to my child and their use of the listed medication(s) may be shared with appropriate school and medical personnel.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*If your child must take acetaminophen or ibuprofen above the weight and/or age dosage recommendations, your healthcare provider must list those medications below with proper dosage instructions.***

**Licensed Healthcare Provider Statement**

I am the licensed healthcare provider for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and have prescribed the following medication(s) that the child will need to take while on a school sponsored field trip/event:

Name of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Administration: \_\_\_\_\_\_\_\_\_\_\_ Route and Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child may self-administer (circle) YES NO

Name of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Administration: \_\_\_\_\_\_\_\_\_\_\_ Route and Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child may self-administer (circle) YES NO

Name of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Administration: \_\_\_\_\_\_\_\_\_\_\_ Route and Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child may self-administer (circle) YES NO

Licensed Healthcare Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE:**

Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Nurse Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Revised 8/1/2019*