Medication Authorization: Fieldwork/Overnight Only — One form per medication

Student Name: _____ Date of Birth: _____ Effective Date(s) :

Parent Completes: **Parental Authorization**

I hereby request that my child receive above medication during field trip. I release the School Board and their agents and employees from all liability that may result from my child taking the medication listed below. I authorize my physician/medical provider to release to the school nurse specific, confidential medical information contained in his/her record about my child in order to deliver health care services to my child.

Medication will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of the child, medication dispensed, dosage prescribed, and expiration date). Over the counter medicine is to be given according to label unless otherwise prescribed by MD, and must be labeled with student's name, medication and full dosing information readable on label.

Parent Signature: _____ Date: _____ Phone: _____

Parent may complete for Over the Counter (OTC) Medication; Physician must complete for alternate dosing of OTC and for all prescription medications

Medication Name_____Dosage_____ Time(s) Medication to be given: A.M._____ P.M. _____

PRN/As Needed for: Frequency_____ Has been properly trained & may self medicate: _____

Special Instructions: _____

Side Effects/ contraindications: _____

RX: Physician Signature: _____ Date: _____ Phone: _____

School Staff Completes:

Medication Administration Log Review/Approval date: By

Date								
Amt								
Time								
Count*								
Initials								
Amt								
Time								
Count*								
Initials								
Amt								
Time								
Count*								
Initials								

Codes: R=No Show/Student Refusal** N=No medication/suppies available** * after each dose of prescription med. **Notify parent, document below or on back

Medication received by: amount Returned By: amount Initials: Signature:

Medication returned to : amount Received From: amount Initials: Signature: