FILE: JHCD-AF4
CRITICAL

ADMINISTRATION OF MEDICATIONS TO STUDENTS ON FIELD TRIPS AND EXCURSIONS

(Permission Form and Authorization for Medications)

Student Information

Name: _____ Age: _____ Date of Birth: _____

School: _____Grade: _____Homeroom/Teacher:_____

Date(s) of Field Trip:_____

Medication: _____

Dosage: _____

Physician Name:_____Phone:_____

Parental Permission

I give permission for _____ to receive the above medication during the field trip on the date(s) above.

_____ Student may possess and self-administer the above medication. (**If yes, *Treatment Plan and Physician Certification*, below, must be filled out**).

_____I do not authorize my student to possess or self-administer the above medication. I give District employees permission to possess and administer student medication in accordance with the ***original prescription label***. I also give district employees permission to contact the student's physician directly to provide information on the student's condition or clarify medication administration instructions and this form shall act as an Authorization for the physician to communicate with the District. I understand that the District and its employees or agents may disclose information relating to the student's medication as may be necessary to protect the student's health. The district will incur no liability for such disclosure. I understand that I have the responsibility for providing the school with an adequate supply of medication for the duration of the trip ___ school days in advance of departure. I verify that the Student has previously received the first dose of medication.

I understand that while on the field trip, my student is subject to the District's code of conduct and may be subject to discipline for violation of the code of conduct, including referral to law enforcement. I further understand that the District and its employees or agents shall incur no liability as a result of any injury arising from the administration of medications by the Student or the District, absent negligence by the District, its employees or its agents. I shall indemnify and hold harmless the District and its employees, agents, and representative against any claims arising out of the possession or self-administration of medication by the Student.

Signature: _____ Date: _____

Relationship: _____Phone: _____ Emergency Phone: _____

Medication/Prescription Information and Treatment Plan and
Physician Certification for Possession and Self-Administration of Medication
(To be completed by physician)

Medication	*Dosage/Frequency*	*Condition Being Treated*	*Physician Comments*

**Drug Allergies (list):_____

I certify that I am a licensed physician authorized by law to prescribe the Medication set forth in the above Treatment Plan. I have instructed Student in the correct and responsible use of Medication. Student is capable of self-administering Medication in accordance with the Treatment Plan and has demonstrated to me or my designee the skill level necessary to self-administer Medication.

_____
Signature of Physician

_____
Date

For District Use Only

I have observed _____ on _____ (date) satisfactorily demonstrating the proper technique for the self-administration of _____(name of medication or device.)

_____ _____
School Nurse Date

Lee's Summit R-7 School District Fieldtrip Medication Record

Student:_____DOB:_____ Sponsor:_____ Year:_____ School:_____

Medication:_____ Label Instructions/Time:_____

Medication:_____ Label Instructions/Time:_____

Medication:_____ Label Instructions/Time:_____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															X
October																															
November																															X
December																															
January																															
February																													X	X	X
March																															
April																															X
May																															
June																															X
July																															

Signature of Person Administering Medication	Initials	Date

Date	Pharmacy For prescription medications	Rx # For prescription medications	Qty Received	Signature(s)