WASHINGTON COUNTY PUBLIC SCHOOLS/MERITUS HEALTH SCHOOL HEALTH PROGRAM
OVERNIGHT FIELD TRIP MEDICATION/TREATMENT PERMISSION FORM

This form must be completed and signed by the student's health care provider and parent/guardian for all prescription and over the counter medications.

- A new form is required for each overnight field trip.
- A separate form must be completed for each medication.
- Students are not permitted to carry medication on school buses, school grounds or on overnight field trips.
- The medication must be brought to school by a parent/guardian or responsible adult ONE WEEK PRIOR TO FIELD TRIP to the health room.
- Prescription medications must be in a labeled prescription container with specific instructions.
- Over the counter medications must be in the original, unopen container.

HEALTH CARE PROVIDER INSTRUCTIONS FOR GIVING MEDICATION ON SCHOOL OVERNIGHT FIELD TRIP

Student Name: _____ Date of Birth: _____ Grade: _____

Allergies: _____

Medication Name: _____ Route: _____

Treatment: _____

Reason for Administration: _____

Exact Dose to be Given (Must specify in mg and/or # of puffs) _____

Time/Frequency of Administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Note: a student may NOT carry medication at any time. However because of a serious medical condition, a student may need to carry an inhaler for asthma or EpiPen for severe allergic reactions.

☐ Student has permission to carry/self-administer emergency medication.

☐ Student has permission to self-administer with WCPS Staff oversight.

Parent Signature _____

Student Signature _____

School Nurse Signature _____

Health Care Provider Signature _____

Health Care Provider Signature: (no stamps) _____ Date: _____

Health Care Provider Name (Printed) _____

Phone: _____ Fax: _____

I request designated school personnel to safe guard and if needed, to administer the medication as prescribed by the above health care provider.

Parent/Legal Guardian Signature: _____ Date: _____ Phone: _____

School Nurse: Received and reviewed for accuracy by _____ Date _____

FOR SCHOOL PERSONNEL USE ONLY

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

School personnel must sign and initial below before administering medication and/or verifying order for accuracy.

INIT	NAME	INIT	NAME	INIT	NAME

File in student health file upon return from field trip.