SCHOOL DISTRICT OF JEFFERSON
GUIDELINES FOR IMPLEMENTATION

Reference Code: IGDEC-E(3)

Administering Medication to Students on Overnight Trips

(Please return to your child's school)

Student Name_____ Physician's Name_____

Parent/Guardian_____ Physician's Phone_____

My son/daughter has the following health conditions: (asthma, diabetes, seizures, severe allergies, migraines, etc.)

Please specify: _____

List any allergies: _____ EpiPen required _____Yes _____ No

Please Check One:

- ❒ My son/daughter will not be bringing medications on the trip.
- ❒ My son/daughter has my permission to carry and self-administer the following medications on the trip. **Students are not allowed to carry or self-administer medications that are designated as controlled substances (e.g., Ritalin).**
- ❒ I request that a school staff member administer the following medications to my son/daughter during the trip.

---

1. Medication:_____ Dosage:_____ Frequency:_____

   *Emergency Medications (inhaler, glucagon, insulin, epi-pen). Student to self-administer/carry: ❒ YES ❒ NO

   Time(s) to be given:_____ Reason for this medication:_____

   If given on an "as-needed" basis, please describe:_____

2. Medication:_____ Dosage: _____ Frequency:_____

   *Emergency Medications (inhaler, glucagon, insulin, epi-pen). Student to self-administer/carry: ❒ YES ❒ NO

   Time(s) to be given:_____ Reason for this medication:_____

   If given on an "as-needed" basis, please describe:_____

3. Medication:_____ Dosage: _____ Frequency:_____

   *Emergency Medications (inhaler, glucagon, insulin, EpiPen). Student to self-administer/carry: ❒ YES ❒ NO

   Time(s) to be given:_____ Reason for this medication:_____

   If given on an "as-needed" basis, please describe:_____

I, the prescribing physician, am willing to accept direct communication from the person dispensing and administering the above medication.

Physician's Signature_____ Date_____
(Signature required for all prescription medication; signature is valid through July 31 of this academic fiscal year.)

Parent/Guardian Consent:

- I hereby grant permission for my son/daughter to take the above medications while on the field trip, as ordered, and authorize school personnel to contact my child's physician if necessary.
- I agree to provide the medication in the original, properly labeled container. Pharmacy label is required for all prescription medications.
- Emergency first aid will be given by teacher, trip authority, or other qualified person.
- In the case of serious injury/illness the child will be transported to the nearest hospital for examination by a physician. Reasonable effort will be made at contacting the parent/guardian listed above.

_____ _____
Medical Insurance Group Policy Number

Parent/Guardian Signature_____Date_____
(Signature required for all prescription and nonprescription medication).

FUTURE OVERNIGHT FIELD TRIPS DURING CURRENT SCHOOL YEAR

OVERNIGHT FIELD TRIP #2 WITHIN CURRENT SCHOOL YEAR

Date of Overnight Field Trip #2:_____ Destination:_____

I have reviewed the above listing of medications and confirm they are current.

Parent Signature: _____ Date: _____

OVERNIGHT FIELD TRIP #3 WITHIN CURRENT SCHOOL YEAR

Date of Overnight Field Trip #3:_____ Destination:_____

I have reviewed the above listing of medications and confirm they are current.

Parent Signature: _____ Date: _____

8/26/19