HENRY COUNTY PUBLIC SCHOOLS – MEDICATION AUTHORIZATION FOR EXTENDED DAY / OVERNIGHT FIELD TRIP FOR MIDDLE AND HIGH SCHOOL

Student Name: ______________________________ **Student Age:** ____ **Date of Birth:** ___________ **Grade:** ___
List all known allergies: ____

Field Trip Location(s): ____ **Dates**: ___________________________
Supervising School Staff: ____

Procedure:

***Completed med forms must be turned in 1 week prior to the scheduled trip.**
***All medications must be turned in to the supervising school staff prior to departure.**
***The medication must be in the original container with only enough medication for the trip.**
***The supervising HCPS staff will be responsible for keeping all medications in a safe and secure place while on the field trip. *Students are not allowed to carry any medication (expect emergency medications (ie.. inhaler, epipen) with MD consent).**
***At the scheduled time, medication will be given to the student by the supervising staff to "self-administer in their presence".**

Name & Dose of Medication: _________________________________ **Reason for Medication:** _____________________
Form of medication/treatment: [ ] Tablet/capsule [ ] Liquid [ ] Inhaler [ ] Injection [ ] Nebulizer [ ] Other _____________
Instructions (Dates/Times to be given): ____
Important side effects: [ ] No [ ] Yes (describe) ____

DATE	TIME	Teacher Initials	DATE	TIME	Teacher Initials	DATE	TIME	Teacher Initials

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DATE	TIME	Teacher Initials	DATE	TIME	Teacher Initials	DATE	TIME	Teacher Initials

***By signing below, I acknowledge that the school employee is NOT responsible for administering the medication. The named student has been instructed on the use and necessity of this medication and I/we acknowledge that he/she is capable and competent to safely and effectively administer the above named medication independently in the presence of a trained staff person.* I/we expressly hold harmless, and waive any liability on behalf of the school or its employees and agents concerning any injuries or reactions resulting from the administration of this medication, any adverse effects or side effects resulting from the self-administration of, or a student's refusal to take or administer this medication**

****TO BE COMPLETED BY PHYSICIAN**** **(Prescription Medication Only):**

Physician signature: ____ Date: __________________
MD name: ______________________________ Phone: ____________________ Fax: ______________________

****TO BE COMPLETED BY PARENT/GUARDIAN**** **(Over the counter and Prescription medications)**

Parent Signature: ___________________________________ Relationship to child: _______________________
Date: ____________ Home phone: ______________ Work phone: ______________ Cell phone: ______________