River Valley School District For Grades 9-12 Only

Self-Administration of Medication on Overnight Field Trips Health Care Provider and Parent Permission Form

This form should accompany the "Student Health Information Form for Overnight School Field Trips" form and can be used for multiple trips during the same school year if all information remains the same.

Date:						
Student:		School	: Grad	e:	DOB:	
rather than at school v	whenever possible.	School persor	lications should be adm nnel, designated by the nd appropriate training	school nurse, r		
	· · · · · · · · · · · · · · · · · · ·		dministered under this nspect, and oversee the		ctitioner prescribing the n of such medication."	
We require a written of self-administer medical		•		he parent/gua	rdian for the student to	
School Nurse	S	chool	Phone		Fax	
This	section to be	complete	ed by Medical Pr	ovider/Pre	escriber	
	(Student name)			ollowing physic	ian/licensed health care	
provider ordered med	ication during this s	chool sponsor	ed overnight field trip:			
Medication	Dose	Route	Frequency/Time of day	Side effects Physician	to be reported to	
			•	•	nsored overnight field trip medication administration.	
Medical Provider Signatu	ure			Date:		
Medical Provider Name ((please print)		Telephone#			
Address:						

TYLENOL / IBUPROFEN

Parent/guardian must complete the information below. If the dose exceeds the recommendations on the bottle/package, a physician's order is required.

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Medication	Dose	Route	Frequency	Reason
Tyl Tylenol				
Ibu Ibuprofen				
For students with frequent ailments (headaches, allergies, stomach aches, etc) that require frequent use of medication parent will be required to supply medication for school. Medication will be administered according to product instructions unless specified				
Parent/Gu	ardian Auth	orizatior	1	
I/we request that our student be able to carry and ta sponsored overnight field trip.	ke their own med	lication and/	or syringe during this	school
I/we agree to deliver a medication supply sufficient for the supply supply sufficient for the supply supp				ation for the
I /we hereby release the Board of Education and it's a my child taking the prescribed medication. I also, accadinistration, transportation and possession of any	cept all responsib	ility and liab	ility involved with the	safe
Parent/Guardian Signature	Da	te:		
Stud	ent Agreem	ent		
l agree to:				
1. Follow my prescribing health professional's n	nedication orders	i .		
2. Use correct medication administration techn				
3. Not allow anyone else to use my medication.				
4. Notify the school personnel if I suspect that I	am experiencing	side effects	from my medication	
5. Other:6. I understand that permission for self-adminis	etration of modica	tion may be		abla ta maintain
I understand that permission for self-adminis the procedure safeguards established above.		ition may be	suspended if Fam una	ible to maintain
Signature of Student		Date		
The student has demonstrated knowledge about and	I proper use of his	s/her medica	ition.	

Date

Signature of School Nurse