RIVER VALLEY SCHOOL DISTRICT

660 West Daley Street ≈ Spring Green, Wisconsin 53588 ≈ Phone: 608-588-2551

452.4 Exhibit 3

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

(For Grades 9-12 Only)

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_____ Grade_____ DOB_____

The policy of the River Valley school district states "medications should be administered to school children at home rather than at school whenever possible. School personnel, designated by the school nurse, may administer medications to students under established conditions and appropriate training required by the Department of Public Instruction.

In all instances where prescription medication is to be administered under this policy, the practitioner prescribing the medication has the power to direct, supervise, decide, inspect, and oversee the administration of such medication."

We require a written order from a licensed prescriber and authorization from the parent/guardian for the student to self-administer medication. Please return this form to the school nurse.

_____	_____	_____	_____
School Nurse	School	Phone	Fax

This section to be completed by Medical Provider/Prescriber

Please allow _____ to self-administer the following physician/licensed
(Student Name)
health care provider ordered medication during this school sponsored overnight ~~field~~ school trip:

Medication	Dose	Route	Frequency/Time of day	Side effects to be reported to Physician

I authorize the student named above to self-administer this medication during this school sponsored overnight ~~field~~ school trip and thereby release the school nurse or designated school personnel from liability regarding medication administration.

Medical Provider Signature_____ 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.

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/Guardian Authorization

I/we request that our student be able to carry and take their own medication and/or syringe during this school sponsored overnight ~~field~~ school trip.

I/we agree to deliver a medication supply sufficient for the duration of this ~~field~~ trip (only enough medication for the trip) in a pharmacy-labeled container or original manufacturer's container to the school.

I /we hereby release the Board of Education and its agents and employees from any and all liability that may result from my child taking the prescribed medication. I also, accept all responsibility and liability involved with the safe administration, transportation and possession of any medication that my student will be self-administering.

Parent/Guardian Signature_____Date_____

Student Agreement

I agree to:

1. Follow my prescribing health professional's medication orders.
2. Use correct medication administration technique
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-administration of medication may be suspended if I am unable to maintain the procedure safeguards established above.

_____ _____

Signature of Student Date

The student has demonstrated knowledge about and proper use of his/her medication.

_____ _____

Signature of School Nurse Date

Policy #452.4 - Administering Medication to Students
Policy #452.4-Rule 1 - Administering Medication Procedure
Policy #452.4-Rule 2 - Medication Error Procedure
Policy #452.4-Rule 3 - Disposal of Medical Waste
Policy #452.4-Exhibit 1 – Medication Administration Information
Policy #452.4-Exhibit 2 – Medication Incident Report Form

APPROVED: October 14, 2021