School: _____*SILSA*_____ Field trip: ___*DC: 3/27-3/30*_____

Overnight Field Trip Medication Form

Student's name: _____ Date of birth: _____

Name of medication: _____ Dose: _____

- ***Each medication requires a separate form***

Time(s) to be given: _____ **OR** As needed every _____ hours for _____

Significant information/contraindications: _____

Physician's Signature: _____ Date: _____

- ***Required for ALL medications (over-the-counter & prescriptions)***

****

I hereby give permission for my child, _____ to receive medication as listed above during the school-sponsored trip. As the parent/guardian, I assume responsibility for any adverse reactions this medicine may cause for my child.

I agree to send the prescribed medication in a container properly labeled by a pharmacist. Nonprescription medicine will be sent unopened in the original container.

_____

Signature of parent Date

_____

Cell phone number Additional emergency name & telephone number

****

For School Use Only:

Date	Thursday 3/27	Friday 3/28	Saturday 3/29	Sunday 3/30
Time(s) given				
Initials				

_____ _____ _____ _____

Initials Admin Signature Initials Teacher Signature

School: _____*SILSA*_____ Field trip: ___*DC: 3/27-3/30*_____

Overnight Field Trip Medication Form - Opt out

Student's Name: _____ Date of birth: _____

My child, _____ will not be bringing any prescription or over-the-counter medications on this trip.

_____

Signature of Parent Date

_____

Parent's Name Telephone number

****** All students are required to submit this form if not bringing any medications. ******