

## Extended Field Trip Medication Form- Elementary Level (KG-5th)

**Purpose:** This form must be completed for every student taking any medication on an extended field trip outside of the regular school day. Medication includes prescription, over-the-counter, herbal/homeopathic, and (non)essential oils. Please see Jeffco BOE Policy [Administering Medicines to Students](#) for more information.

- This form must be returned to the Field Trip Coordinator **4** weeks before departure, allowing for necessary review and planning.
- All medications must be checked in with the Field Trip Coordinator 1-2 days before departure.
- Please review the parent checklist to make sure all information is complete.
- If your school is providing any over-the-counter medications, they must be listed below. Please ask your Field Trip Coordinator for the list of provided medications.

This form must be completed by a **medical provider with prescriptive authority in the state of Colorado and signed by a parent/legal guardian UNLESS no medications are being brought from home.** Parent or legal guardian can sign for OTC medications below without a medical provider's signature.

STUDENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
Health Concerns: \_\_\_\_\_ Age: \_\_\_\_\_  
Allergies: \_\_\_\_\_

### **REQUIRED: OVER-THE-COUNTER (OTC) MEDICATION PERMISSION:**

The following over-the-counter medications may be provided by your field trip coordinator and will be administered per the manufacturer's directions. These medications are the most commonly used medications for mild discomfort while away from home. Please provide parent approval for administering these medications, as needed. Please also confirm your child's weight per weight-based dosing. The field trip coordinator will only be able to administer these OTC medications with your approval.

I give my permission for my child to receive these OTC medications as needed while on the trip:

**(This option is not available for international trips or trips where a nurse's license is not recognized. Contact your District RN with questions.)**

1. Acetaminophen (Children's Tylenol) - minor aches and pains
2. Ibuprofen (Children's Advil or Children's Motrin) - minor aches and pains
3. Diphenhydramine (Benadryl) - for mild allergic reactions. This will not be used for seasonal allergies.

Parent Signature: \_\_\_\_\_

Child's Weight in lbs: \_\_\_\_\_

**Please provide the following information for each medication to be administered on the trip:**

Medication #1: \_\_\_\_\_  
CHECK ONE: As needed \_\_\_\_ Daily \_\_\_\_  
TIMES TO BE GIVEN: \_\_\_\_\_ AM/PM DOSE: \_\_\_\_\_  
REASON FOR GIVING: \_\_\_\_\_  
Special Instructions: \_\_\_\_\_

Medication #2: \_\_\_\_\_  
CHECK ONE: As needed \_\_\_\_ Daily \_\_\_\_  
TIMES TO BE GIVEN: \_\_\_\_\_ AM/PM DOSE: \_\_\_\_\_  
REASON FOR GIVING: \_\_\_\_\_  
Special instructions: \_\_\_\_\_

Medication #3: \_\_\_\_\_  
CHECK ONE: As needed \_\_\_\_ Daily \_\_\_\_  
TIMES TO BE GIVEN: \_\_\_\_\_ AM/PM DOSE: \_\_\_\_\_  
REASON FOR GIVING: \_\_\_\_\_  
Special Instructions: \_\_\_\_\_

Medication #4: \_\_\_\_\_  
CHECK ONE: As needed \_\_\_\_ Daily \_\_\_\_  
TIMES TO BE GIVEN: \_\_\_\_\_ AM/PM DOSE: \_\_\_\_\_  
REASON FOR GIVING: \_\_\_\_\_  
Special instructions: \_\_\_\_\_

Medication #5: \_\_\_\_\_  
CHECK ONE: As needed \_\_\_\_ Daily \_\_\_\_  
TIMES TO BE GIVEN: \_\_\_\_\_ AM/PM DOSE: \_\_\_\_\_  
REASON FOR GIVING: \_\_\_\_\_  
Special Instructions: \_\_\_\_\_

Medication #6: \_\_\_\_\_  
CHECK ONE: As needed \_\_\_\_ Daily \_\_\_\_  
TIMES TO BE GIVEN: \_\_\_\_\_ AM/PM DOSE: \_\_\_\_\_  
REASON FOR GIVING: \_\_\_\_\_  
Special instructions: \_\_\_\_\_

**Sunscreen, lip balm, and insect repellent** are to be provided by the parent, but do not require a medical provider's signature. I give my permission for my child to apply these items while on the trip.

Parent Signature: \_\_\_\_\_

I approve the administration of the above medications as indicated. I understand that if an Individualized Student Health Plan (ISHP) is required for a known health condition, it is my responsibility to notify the district RN and the school administration **8** weeks before departure. A school meeting to discuss health planning/ accommodations may be required. According to BOE policy JLC and Colorado Nursing Board Policy #30-04, district nurses have the obligation to call physicians directly to verify orders if needed.

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Medical Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

District RN review for delegated trips: \_\_\_\_\_ Date: \_\_\_\_\_