North Royalton City Schools
Extended Field Trip Medication Administration Form

(Complete this form if your student requires prescription AND/OR over-the-counter medication not supplied by NRSD)

Student name	Date of Birth

PRESCRIPTION MEDICATIONS REQUIRED ON THIS TRIP:

I request and give consent to a volunteer chaperone/teacher/nurse that has been authorized by the North Royalton School District to administer the PRESCRIBED medication(s) listed below to my child. ***I will provide medication in accordance with the North Royalton City Schools Field Trip Medication Policy (attached).*** I further agree to hold harmless the Board of Education, all school employees, and volunteers from any and all liability for damages or injury caused by the administration of medication to my child.

I have provided the following **'prescribed'** ***DAILY*** medication(s) listed below and my student should receive them on the extended field trip only. This authorization will be revoked upon completion of the trip. (***Please note that a medical practitioner's signature IS required if prescriptive medication will be administered to your child during the trip.)*** *****ALL MEDICATION IS DUE NO LATER THAN APRIL 14, 2027*****

	Medication	Dosage	Time to Administer	Purpose of Medication	Side Effects/ Special Instructions
1					
2					
3					

Medical Practitioner's Signature:_____ Date:_____

Medical Practitioner's Name (Printed):_____ Phone:_____

NON-PRESCRIPTION MEDICATIONS REQUIRED ON THIS TRIP (SUPPLIED BY PARENT):

I request and give consent to a volunteer chaperone/teacher/nurse that has been authorized by the North Royalton School District to administer the non-prescription/over the counter medication(s) listed below to my child. ***I will provide medication in accordance with the North Royalton City Schools Field Trip Medication Policy (attached).*** I further agree to hold harmless the Board of Education, all school employees, and volunteers from any and all liability for damages or injury caused by the administration of medication to my child.

	Medication	Dosage	Time to Administer	Purpose of Medication	Side Effects/ Special Instructions
1					
2					
3					

☐ **Check this box if your child currently has the above ordered medication in the school clinic and you are requesting that we utilize that medication for the field trip. (i.e.: EpiPen). Please note that this form still must be completed in its entirety according to the Field Trip Medication Policy.**

Parent Signature:_____Date:_____
Best phone number:_____ Alternate number(s)_____