Medication Authorization for Field Trips

Any medication that must be administered during a field trip, either over the counter or prescribed, requires parent/guardian authorization. This applies to any medication given by mouth, injection, or applied topically.

- **The required medications must be provided to the school in the original container with proper labeling, as required by OK State Department of Health guidelines.**
- One form is needed for each trip.
- Please send only the amount needed for the length of the trip.
- Prescription medications will only be administered as prescribed by the physician, noted on the prescription label.
- Over the counter medications will be given per your instruction, provided this corresponds with label instructions. (Ibuprofen, Acetaminophen, and Diphenhydramine will be administered per your child's Emergency Information form that is on file with the nurse's office.)
- Only FDA approved medications will be accepted.
- Students are not allowed to carry any medications with the exception of Epi-pens (9th-12th grade) and inhalers (6th-12th grade).
- Medications will be given by a Holland Hall School employee/chaperone authorized to administer medication.

I hereby certify that it is necessary for ____________________________ DOB:__________ Grade:_______
(child's name)
to be administered the medication(s) listed below when he/she is away from school property on an approved school field trip. (Please complete one for each medication. These will be used to administer the medication.)

Parent/Guardian signature: ________________________________ Date: ___________________

Child's name __________________________ Medication _________________________
Dosage to be given: _______________ caps/pills/tabs Time(s): ____________________
Reason for Medication (Diagnosis): ____
(For as needed medications, please note the reason for administration. Ex: for headache)

Child's name __________________________ Medication _________________________
Dosage to be given: _______________ caps/pills/tabs Time(s): ____________________
Reason for Medication (Diagnosis): ____
(For as needed medications, please note the reason for administration. Ex: for headache)

Child's name __________________________ Medication _________________________
Dosage to be given: _______________ caps/pills/tabs Time(s): ____________________
Reason for Medication (Diagnosis): ____
(For as needed medications, please note the reason for administration. Ex: for headache)

Child's name __________________________ Medication _________________________
Dosage to be given: _______________ caps/pills/tabs Time(s): ____________________
Reason for Medication (Diagnosis): ____
(For as needed medications, please note the reason for administration. Ex: for headache)