Ripon Area School District

Medication Authorization Form for Overnight Field Trip

Student Name:	Date of Birth:	Grade:

Administration of medication to students on overnight field trips shall be done only when the student's health may bejeopardized without the medication. Generally, health services staff do not accompany students on field trips. Any prescription medication to be administered by the student will be kept in the possession of the teacher or designated district staff. With physician and parent consent, exceptions will be made for secondary students to carry inhalers, Epi-injectors, diabetes medication, and non-prescription pain relievers.

The administration of ANY medication, prescription or non-prescription, during overnight field trip requires:

1. The original labeled container;
2. A written physician's order and written permission by the parent for any self-administration of prescriptionmedications (section A below);
3. Written permission by the parent (including dosage & usage), for self-administration of medication, including non- prescription over-the-counter medications (section B below).

The parent is responsible for providing the medication to the teacher before departure. Please send only the amount needed for the field trip in the original container.

To authorize the self-administration of medication or other health procedures, please complete the form below and return it to the classroom teacher.

Section A
PHYSICIAN/LICENSED PRESCRIBER ORDER FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

I hereby authorize the self-administration of the following medication during the overnight field trip and release schoolpersonnel from liability should reactions result from the medication administered by them:

	Self carry inhaler	Yes	No
	Self carry Epi-injector	Yes	No
	Self carry diabetes medications	Yes	No

Name of medication:_____ Dosage:_____ Time:_____

Possible side effects include: _____

Name of medication:_____ Dosage:_____ Time:_____

Possible side effects include: _____

Name of medication:_____ Dosage:_____ Time:_____

Possible side effects include: _____

Physician's Signature:_____ Date:_____ Phone:_____ Fax:_____

Parent/Guardian Signature:_____ Date: _____

Section B
PARENT PERMISSION FOR NON-PRESCRIPTION MEDICATION

I give my permission for my child to self-administer over-the-counter (OTC) pain reliever medication(s) such as Tylenol, aspirin, Motrin, or naproxen, as well as antihistamines such as Zyrtec, Claritin, Benadryl, or Allegra on the field trip. These medications are given per package instructions and are to be provided by parent. If dosing exceeds package instructions physician approval is required. I am aware that there will be no adult supervision regarding administration of OTC medications and my child is aware that under no circumstances that any medication is ever shared.

OTC medication:_____ Time:_____

OTC medication:_____ Time:_____

OTC medication:_____ Time:_____

Parent/Guardian Signature:_____ Date: _____

FOR OFFICE USE ONLY

Information reviewed & agreed to by:

School Nurse: _____ *Date*: _____ *Teacher*: _____ *Date*: _____

Ripon Area School District

Overnight Field Trip Authorization/Health Form

PARENT OR GUARDIAN - Complete this section

Student Name: (Last, First, MI)	Date of Birth:	Gender:
Address: (Street, City, State, Zip)		
Parent Name: (Last, First, MI)		
Address: (if different than child)		

Home Phone:	Cell Phone:	Work Phone:
Health Insurance Carrier:	Policy No.	
Primary Care Physician:	Physician Office Phone:	

Emergency Contact: (if unable to reach parent)		Relationship:
Home Phone:	Cell Phone:	Gender:

HEALTH INFORMATION (Please check (✓) appropriate areas below:	**Yes**	**No**
Does the student require the administration of any medication during the trip? If yes, pleasecomplete the Medication Authorization Form for Overnight Field Trips on reverse side.		
Any allergies? If yes, please list and describe any reaction.		
Asthma? If yes, please explain any triggers or signs the teacher should be aware of.		
Diabetic? If yes, list medications required.		
Headaches?		
Fainting?		
Heart condition? If yes, please describe.		
Seizures? If yes, type.		
Vision impairment?		
Hearing impairment?		
Any physical activity restrictions? If yes, please describe.		
If other not specifically addressed, please explain:		
Other information or directions from parents.		

In case of emergency, I hereby authorize the school officials and designated chaperones to secure emergency care for my child at an appropriate emergency facility. I understand that, should a medical emergency arise, every effort will be made to contact me before such treatment is given. I understand that any changes to this authorization must be submitted to the school principal in writing.

Parent/Guardian Signature:_____ Date: _____

State of Wisconsin Fond
du Lac County
This instrument was acknowledged before me on _____
By_____(Signature of Notary Public)
_____(Printed Name)
Notary Public, Wisconsin.
My commission expires on _____