EXTRACURRICULAR/CO-CURRICULAR TRIP MEDICATION AND HEALTH AUTHORIZATION FORM

STUDENT NAME _____ DATE OF BIRTH _____

ADDRESS _____ GRADE _____

Medical Diagnosis for the following medications (e.g. asthma, allergies, etc.): _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN

SELF-CARRY & ADMINISTRATION OF EMERGENCY PRESCRIPTION MEDICATION:

Reason	Name of Medication	Dosage	Frequency
Allergy (Epi Pen)			
Asthma			

PRESCRIPTION MEDICATION:

Reason	Name of Medication	Dosage	Frequency

PHYSICIAN SIGNATURE _____ DATE _____

PHYSICAN PRINTED NAME _____ PHONE _____

NONPRESCRIBED MEDICATION:

Reason	Name of Medication	Dosage	Frequency

A. I understand that all medications listed above (other than the self-carry meds) will be self-administered in the presence of an authorized staff member.
B. I will assume responsibility for safe delivery of medication to designated personnel.
C. I will notify the District trip coordinator immediately if there is any change in the use of the medication.
D. I release and agree to hold harmless the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ Date _____

_____

Primary Telephone Number _____ Additional Telephone Number _____

STUDENT NAME _____ DATE OF BIRTH _____
ADDRESS _____ GRADE _____

Facts concerning the student's medical history to which medical staff should be alerted.

- Please note: To insure student safety, information noted here may be shared with appropriate school staff.

Medical diagnosis (e.g. asthma, diabetes): _____

Allergies (food, meds, bees): _____

Physical impairments: _____

Date of last tetanus shot _____/_____/_____

Medications taken regularly (include dosage):_____

_____

- While attending co-curricular **overnight trips** only; I give my permission for authorized school personnel to supply, store, and administer the following nonprescription medication to my child at the dosage indicated on the manufacturer's packaging for the child's age and/or weight on an as needed basis.

- Please check all that apply and circle dosage preference:

____Ibuprofen 200mg (Motrin, Advil)	1 tablet	2 tablets
____Tylenol (Acetaminophen) 325mg	1 tablet	2 tablets
____Benadryl (OTC)	1 tablet	2 tablets

____Tums: As needed not to exceed 12 in 24 hours

____Hydrocortisone Cream: As needed/directed

____Benadryl Cream: As needed/directed

____Antibiotic Cream: As needed/directed

____Cough Drops

FAMILY PHYSICIAN _____ PHONE_____

FAMILY DENTIST _____ PHONE_____

SPECIALIST _____ PHONE_____

I hereby give my consent in the event that all reasonable attempts have been made to contact me at the contact numbers provided have been unsuccessful, for the administration of any treatment deemed necessary by any hospital reasonably accessible.

This authorization does not cover major surgery unless medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery are obtained prior to the performance of such surgery.

Parent/Guardian Signature _____ Date _____

1/14/13
3/18/13