

EXTRACURRICULAR/CO-CURRICULAR TRIP MEDICATION AND HEALTH AUTHORIZATION FORM

STUDENT NAME		DATE OF BIR	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 Num	nber	
STUDENT NAME	DATE OF BIRTH		
ADDRESS	GRA	VDE	
Facts concerning the student's me • Please note: To insure student safe	dical history to which medical staff sh ty, information noted here may be shared with appr	ould be alerted. ropriate school staff.	
Medical diagnosis (e.g. asthma, diak	petes):		
Allergies (food, meds, bees):			
Physical impairments:			
Date of last tetanus shot/	/		
Medications taken regularly (include	e dosage):		
authorized school personne nonprescription medication to	r <u>overnight trips</u> only; I give mel to supply, store, and adminismy child at the dosage indicated on and/or weight on an as needed basis.	ster the following the manufacturer's	
Please check all that apply and	d 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: A	s needed/directed		
Benadryl Cream: As nee	ded/directed		
Antibiotic Cream: As nee	eded/directed		
Cough Drops			
FAMILY PHYSICIAN	PHONE	<u> </u>	
FAMILY DENTIST	PHONE		
SDECIALIST	DHONE		



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	
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1/14/13 3/18/13