INDEPENDENT SCHOOL DISTRICT 110
Waconia Public Schools

Medication Administration – Field Trip and Student Travel

This form goes along on all destination tours/activities. Please, fill out completely.

Student Name: ______________________________ **Date of Birth:** ______________

School District 110 acknowledges that some students may require prescription and over-the-counter medications to be administered during field trips and student travel. For parents requesting medication to be administered during field trips and student travel, parents must provide ISD 110 the following:

- Medication(s) in an appropriately labeled container, over-the-counter medications must be in original container(s) and prescription medications in a prescription bottle.
- Parent/Guardian permission and signature and physician/licensed provider signature.
- The **only** medications students are allowed to self-carry and/or self-administer on the trip are: **(prescription asthma medications, prescription epinephrine, and non-prescription pain relievers in a manner consistent with labeling)**.
  - Students are allowed to self-carry the above listed medications only if parent/guardian signs authorization to self-carry and student understands his/her responsibility of self-carrying *See Authorization to Self-Carry Section Below.*
- ISD 110 **WILL NOT** provide any stock medications including aspirin, acetaminophen, ibuprofen, cough drops, etc.

Medications: ***Students are only allowed to self-carry prescription asthma and epinephrine and non-prescription pain relievers in a manner consistent with labeling.*** **Chaperone Administered** **Student Self-Carry**

Medication:______________________ Dose:__________ Frequency:______________ ☐ ☐

Staff use only - Date, Time and Dose of Medication Administrated & Initials of Person Giving Medication:

Medication:______________________ Dose:__________ Frequency:______________ ☐ ☐

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Staff use only - Date, Time and Dose of Medication Administrated & Initials of Person Giving Medication:

Physician/licensed prescriber signature: ____________________________ **Date:** ____________________

Print Name of Prescriber: ______________________ **Clinic:** ____________ **Phone:** ______________

Authorization to Self-Carry ***(ONLY: prescription asthma, epinephrine and non-prescription pain relievers)***

Parent/Guardian and student agree and understand that student will:

- Follow health care provider's orders
- Not allow other students to use medication
- Will adhere to prescription and over-the-counter label instructions
- Keep medication in (e.g. purse, backpack, suitcase, etc.) ________________
- Alert ISD 110 staff if symptoms persist, side effects from medication, and/or any questions regarding medication

I/(We) request and authorize my child to be responsible to self-administer the above listed medication(s) during this event; thereby, releasing school personnel and chaperones from liability should inappropriate usage and/or restrictions result from the medication(s).

Yes___ No___

I understand that medications must be carried in the original (labeled) container and that any prescription and non-prescription medications must be listed on this form.

Parent/Guardian Signature:____________________________ **Date:**________________