



Field Trip Destination _____



Shorecrest High School Health Office

PERMISSION TO ADMINISTER MEDICATION FOR EXTENDED FIELD TRIPS

Shorecrest High School

15343 25th Ave. NE
Shoreline, Wash. 98155
FAX – 206-393-4284
Phone – (206) 393-4308

Student _____

Birthdate _____ Age _____ Grade _____

Parent(s) Guardian(s) _____

Address _____ Phone _____

PHYSICIAN'S ORDERS FOR MEDICATIONS FOR EXTENDED FIELD TRIPS

This INCLUDES over-the-counter medications. Please list the **24 hour medication needs** for daily as well as medications the student may take on an "as -needed" basis. (Tylenol, Imodium, Dramamine, Midol etc.)

I give my permission for student to carry and self-administer the medications. **If physicians/families would like a designated staff member to administer the medications, please write those orders in with the medication directions.**

| Medication | Dosage | Admin. method | Time (hour) to be given |
|------------|--------|---------------|-------------------------|
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| | | | |
| | | | |

Date to start medication _____ Date to discontinue medication _____

This medication is being prescribed for the following reason(s) _____

Possible side effects _____

Other comments _____



Signature of student's physician _____ Date _____ Phone _____

Printed Name of Physician _____

PARENT/GUARDIAN REQUEST FOR MEDICATION ADMINISTRATION FOR EXTENDED FIELD TRIP:

I give my permission for student to carry and self-administer the medications. **If physicians/families would like a designated staff member to administer the medications, please write those orders in with the medication directions.**

(name of physician)

(physician phone number)

I accept responsibility for supplying in the original container (prescription bottle or over-the-counter container), and for immediately notifying the school nurse (or principal) of any change in these instructions.

I give my consent for the confidential information contained on this form to be FAXed to the above named school.

I understand that my name on this form constitutes a waiver by me to the school or staff member for liability for untoward reactions when the medication is administered in accordance with the above directions.



Signature of Parent/Guardian

Date