



Field Trip Medication Form

Please fill out one form for each medication to be given on trip

Student Name: _____ Date of Birth: _____

School Building: _____ Grade: _____

Field Trip Date: _____ Destination: _____

Parent/Guardian Name: _____ Phone: _____

<p>Medication Name: _____</p> <p>Please Check: Daily Scheduled Medication _____ Emergency Medication _____</p> <p>Dose: _____ Route: _____ Scheduled Time: _____</p> <p>Is the medication a controlled substance: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many pills are in the bottle before leaving: _____ How many upon returning: _____</p> <p>Indication for use if EMERGENCY medication: _____</p> <p>_____</p> <p>Potential side effects: _____</p> <p><i>Medication can be given 30 minutes before or 30 minutes after the scheduled time.</i></p> <p>Name of staff member to be giving medication: _____</p>
<p>Administration:</p> <p>Dose given: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Time given: _____ am or pm</p> <p>Medication given without incident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Symptoms present if emergency medication was administered: _____</p> <p>_____</p> <p><i>I maintained the medication in a secure area at all times during the field trip. I documented medication administration on this form and will return it to the school office upon returning to the school. I reported any incidents to the school office/nurse or designated staff. I gave the above medication within the time perimeters allowable by Michigan Law.</i></p> <p>Signature: _____ Date: _____</p> <p>Emergency medication returned to the office: <input type="checkbox"/> Yes <input type="checkbox"/> No If not, reason: _____</p>

If student is a diabetic a para or parent/guardian must attend field trip

The following items must accompany this form:

- Medication authorization signed by both the parent and the physician
 - Medication must be in the original container
- If student is to self carry a self carry form must be signed by student and parent

Person preparing medication for trip: _____ Date: _____

Nurse reviewed, if applicable: _____ Date: _____

If controlled substance or emergency medication, was it returned to the office: Yes No

Witness if controlled substance: _____ Date: _____