Peters Township School District

OFF-CAMPUS FIELD TRIP EMERGENCY MEDICATION FORM

Dear Parent/Guardian:

Your child is participating in a field trip with his/her class during the 20__-20__ school year. Your child's physician or healthcare provider has indicated that, in case of an emergency, your child must receive prescription medication and/or an over-the-counter (OTC) medication as a first treatment. In order to permit your child to self-administer prescription medication and/or an OTC medication in case of an emergency during this field trip, your child's physician or healthcare provider must complete this document and the completed form and medication must be returned by you to the sponsor/coach.

All prescription medication must be in the **ORIGINAL, PHARMACEUTICAL** container. OTC medications must be in their original container. NO medication will be accepted in any other containers or without THIS signed form. NO hand written notes will be accepted. **Only the amount of medication needed for the length of time the student will be away from school, should be sent**.

In the event that your child's physician or healthcare provider changes the medications or dosage required for your child during the school year, you must provide the School District with an updated form that corresponds to the medication and dosage provided for each trip. Medication forms that do not specify the correct medication and/or dosage as indicated on the pharmaceutical or original OTC container will not be accepted.

The sponsor/coach will keep all medication in a sealed container. If your child needs to take the medication, he/she will self medicate under the supervision of the sponsor/coach.

LICENSED HEALTHCARE PROVIDER STATEMENT

I am the licensed healthcare provider/physician for _____ and have prescribed the following medication(s): _____ in the event of an emergency in the amount/dosage as prescribed.

☐ The child is qualified and able to self-administer the prescribe medication.

☐ The child has demonstrated proper knowledge and responsibility for taking the medication as prescribed**.**

☐ The following side effects may occur: _____

_____

Physician/Licensed Healthcare Provider **Date**

I fully understand the directions that have been given to the school by the physician and I give my consent for the medication prescribed below by the physician to be administered to my child at school or for the school to monitor the self-administration of the medication by my child. In consideration of the School District's agreement to use good faith efforts to follow the physician's instructions, I hereby release the School District and its personnel from any liability associated with the administration of this medication either by School District personnel or by my child.

I understand and agree that any medical information may be shared with appropriate school and medical personnel. I authorize necessary school personnel to contact the medical provider named above regarding this medication and to release information regarding my child (named above) to that provider. I authorize the medical provider to release information to the school regarding my child (named above) and his/her medication(s). I understand that this consent is necessary in order to protect the limited confidentiality of medical information and that this consent is limited for the purpose and to the person or entity listed above and will be effective for the present school year. I understand that the disclosed information will be kept confidential and that disclosing school personnel will not be responsible for the re-disclosure of any such information.

I understand that this consent is revocable with written, or if necessary, verbal notice, except to the extent that action has been taken in reliance thereon.

PARENT/GUARDIAN SIGNATURE:_____ Date_____

PRINT PARENT NAME:_____

(Revised 3-18)