Marysville School District

Overnight Field Trip: Medication Request Form

Student Name: _____ Grade: _____Date of Birth: _____

Overnight Trip (name): _____

from _____through _____with _____
Date Date Teacher and School Name

☐ **Elementary: Medication(s) to be administered to student by trained staff**

☐ **Secondary: Medication(s) to be taken by student independently**

Prescription and Over-the-Counter Medication

Name of licensed medical practitioner prescribing medication(s): _____

Name of Medication	Dosage to be Given	Time to be Administered/Taken

As parent/guardian of the above named student, I am responsible for informing school personnel of my student's medication program. I understand only the **prescribed daily dose** is to be sent to school for **each day of the trip**.

→ **The medication must come in the original prescription bottle. Parents of elementary students must deliver student medication and orders to the health room prior to the trip.**

→ **Secondary students are to provide this form to the health room prior to the trip and keep the medication safely with his/her belongings.**

I acknowledge the school district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by my student.

This form allows designated school personnel to contact the physician regarding health or medication issues.

_____ _____ _____
Parent/Guardian Signature Date Phone

_____ _____
Licensed Medical Provider (Signature) **Licensed Medical Provider (Print)**

_____ _____
Date Phone