FIVE TOWN CSD POLICY

OVERNIGHT FIELD TRIP MEDICATION PERMISSION

This form must be submitted on or prior to: ________________ (two weeks prior to trip)

Student Name____ Grade __________ Trip ___________________

Please print clearly, first name and last name

1. MEDICATION LIST

In the event of an emergency, medical personnel must know what **Prescription** medication(s) your child is taking. **Please list all medications - prescription and/or over the counter (OTC):**

Name of Medication	Dose	Time(s) to be administered
___________________________________	_______________	______________________
___________________________________	_______________	______________________
___________________________________	_______________	______________________

2. MEDICATION ADMINISTRATION

Check one box:

- ☐ My child takes no medication.
- ☐ My child may self-administer all medication. I understand my child is responsible for the appropriate storage and safety of their medication.
- ☐ My child is unable to administer their medication. I request a trained staff chaperone administer all medication to my child. **I understand a *Five Town CSD Medication Form* must be completed by a Health Care Provider that lists all the medication (prescription and OTC) and submitted with the medication in the original container to the school nurse two weeks prior to the trip.**

_________________________________ _________________________________ ____________

Parent/Guardian Name Parent/Guardian Signature Date

3. GENERAL OTC MEDICATION

The following medications will be available from a trip chaperone if the student does not have it. The school physician has approved these OTC medications for administration by trained staff chaperones according to the maximum dosages indicated. These OTC medicines are intended for use with minor headaches, minor musculoskeletal pain, or minor rashes.

If you would like a trained staff member to administer any of the OTC medications listed below, please check the appropriate box. Please note that designated staff, although trained to safely administer medications are not necessarily medical professionals.

Name of Medication	Maximum Dose	Time(s) to be administered
☐ Acetaminophen	500mg every 4 hours	______________________
☐ Ibuprofen	400mg every 6 hours	______________________
☐ Benadryl	25mg every 6 hours	______________________
☐ Triple Antibiotic	thin smear every 4 hours	______________________

No more than 2 doses per 24 hours and no more than 2 days in a row without further parent or physician input.

_________________________________ _________________________________ ____________

Parent/Guardian Name Parent/Guardian Signature Date

Please contact the CHRHS nurse at 207-236-7800 x3250 with questions or concerns.

**Go to http://www.fivetowns.net/csd/policyDetail.cfm?itemId=229 to view the entire policy on Administering Medications to Students on Field Trips, JLCD-E.*

Medication Administration Log

Student Name:

	Date	Time	Medication	Reason	Initials
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
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21					
22					
23					
24					
25					

Chaperone Name ____________________________ Chaperone Initials __________

Chaperone Name ____________________________ Chaperone Initials __________

Chaperone Name ____________________________ Chaperone Initials __________

This form must be returned to the school nurse at the end of your trip.

History: First Reading: May 2, 2018
Second Reading:
Adopted: