

**Parent/Guardian Authorization for Medication Administration  
FIELD TRIP MEDICATION**

Student's Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_

Parent/Guardian printed name \_\_\_\_\_

Telephone Number – Home \_\_\_\_\_

Telephone Number – Work \_\_\_\_\_

Telephone Number – Emergency \_\_\_\_\_

Other person(s) to be notified in case of medication emergency:

Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

\_\_\_\_\_

My son/daughter has the following food or drug allergies:

\_\_\_\_\_

- 
- I give permission to have the school nurse or school personnel designated and trained by the school nurse to administer medication to my child while on a field trip.

\_\_\_\_ Yes \_\_\_\_ No (If you agree to the this option, a plan will be developed to train the designated medication administrator in the correct way to give medication and to identify any side effects.)

Parent/guardian signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Student \_\_\_\_\_

School Nurse: \_\_\_\_\_