Peters Township School District
Overnight Student Trip
Medication Form

Dear Parent/Guardian:

Your child is participating in _____ on _____.
If it is essential that your child receive prescription medication and/or an over-the-counter (OTC) medication during this trip, your physician must complete this document. In order for your child to self – administer prescription medicine during the trip, this completed form and medication must be returned by the parent 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**.

The sponsor/coach will keep all medication in a sealed container. When student 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
Student

prescribed the following medication(s): _____

in the amount/dosage and time of administration 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 give my consent for the medication prescribed by the physician to be self-administered by my child during the noted field trip. I release the Peters Township School District and its personnel from any liability associated with the administration of this medication. I understand and agree that any medical information may be shared with appropriate school and medical personnel.

Parent/Guardian Signature **Date**