ST VRAIN VALLEY SCHOOL DISTRICT
MEDICATION GUIDELINES FOR OVERNIGHT/OUT OF STATE FIELD TRIPS

Student Name_____ Date of Birth _____

School _____ Teacher _____

My daughter/son has the following medical condition(s) which require medications:

_____

_____

Medications to be given: (medications must be supplied in their original container) **All** routine daily prescription and PRN medication will be kept with one assigned staff member. The student may carry their inhaler and/or Epi-pen (if applicable).

1. Medication:_____ Dose:_____ Time:_____

2. Medication:_____ Dose:_____ Time:_____

3. Medication:_____ Dose:_____ Time:_____

PROVIDER:

The student listed above _____MAY or _____ MAY NOT self-administer the above medication(s).

Medical Provider Signature: _____ Date: _____

Printed Name: _____ Phone: _____

PARENT:

Self-Medication Authorization: With provider approval signed above, I give my permission for my son/daughter to self-administer the above medications while on the field trip. The student will receive one day's supply of medication each morning by contacting the assigned staff member.

Parent/Guardian Signature _____ Date_____

OR

Supervising Adult Authorization: I give my permission for the assigned staff member to administer the medication I have provided, to my child. I am aware that non-medical personnel will be supervising and administering the requested medications. The student may carry their inhaler and/or Epi-pen, if so ordered.

Parent Signature:_____ Date:_____

Please contact the School Nurse with any questions or concerns: 303-772-7700 ext:_____
e-mail:_____@stvrain.k12.co.us

3/2008 **COPY TO: ____ HEALTH CLERK ORIGINAL TO: _____ TEACHER**

Student's Name_____ **Date of Birth** _____

Medication #1_____ **Dose**_____

DATE	TIME	SIGNATURE

DATE	TIME	SIGNATURE

Medication #2 _____ **Dose** _____

DATE	TIME	SIGNATURE

DATE	TIME	SIGNATURE

Medication #3 _____ **Dose** _____

DATE	TIME	SIGNATURE

DATE	TIME	SIGNATURE