School District of Poynette
School Trip Prescription and Over-the-Counter Medication Consent Form

Student: _____ School: _____ Gr: _____

Address: _____ Home Phone: _____

Emergency Phone Numbers:_____

Physician"s Name: _____ Phone:_____

Medication Name: _____ Dosage:_____

Time(s) to be given: _____ Date to be discontinued_____

Reason for medication:_____

If this medication is to be given "PRN"(as needed), state the conditions under which this medication should be taken. _____

I authorize the School District of Poynette's designated School Trip Director_____, with the School Princpal's consent, to allow the above named child to carry and take his/her own medication in accordance with the directions stated above while on the_____ school trip. I further authorize them to contact the child's physician in case of emergency if I can not be reached. I agree to hold the School District of Poynette, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication while on this trip.
The principal and the designated trip director have the right to determine when a student will not be allowed to carry and administer his/her own medications and I as the parent (or as an adult student) agree to abide by their decision.

I agree to supply the above medication in the need quantities and in the **original container,<u>for the sole use of the above named student.</u>**

Parent/ Guardian Signature_____ Date_____
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This section must be completed by the physician for any <u>prescription medication</u> that the student will be taling.

The physician whose signature is shown below has ordered the administration of the medication described above and agrees to accept communication about the student/medication and understands that while on the school trip the student will be responsiblefor taking his/her medication or that the medication will be given by non-medically trained school persommel. If an inhaler has been prescribed, I, the physician certify that the child has been instructed in its proper use.

Physician's Signature_____ Date_____

Address:_____ Phone_____
3/06jas