OVERNIGHT STUDENT TRIP MEDICATION REQUEST FORM

Student Name: _____ Grade: _____ Date of Birth: _____
Overnight Trip (Name): _____
Dates of Trip: _____ School _____ Teacher _____

Staff administered medication

Self-administered medication

By indicating your child/patient may self-administer their medication you are recognizing the needed responsibility of your child/patient and understanding that the school will not be able to track compliance.

This form must be completed and signed by a parent/guardian for self-administration of the following over the counter (OTC) medications: pain relievers, cough drops, antihistamines, antacids and sunscreen. All other OTCs not listed above requ