THE FRANKLIN ACADEMY
Overnight Field Trip Medication Request Form

Student Name: ______________________ Grade: __________ Date of Birth: ______________

Overnight Trip (Name): ____

Date of Trip: From __________ through __________ with ______________________ (Teacher)

Name of Licenced Health Care Provider: ________________ Phone: ______________________

☐ Staff administered medication

☐ Self-administered medication:

By indicating you wish that your child/patient self-administers 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 only: pain relievers, cough drops, antihistamines, antacids, and sunscreen. All other OTCs not listed above require both parent/guardian and LHP signature. *Students may not self-carry controlled substances*.

Name of Medication	Dosage to be given	Time medication to be administered/taken

Student:

* I agree never to share my medications with another person or use it in an unsafe manner
* I agree that if there is no improvement of my symptoms after using my medications, I will report my symptoms to an adult chaperone present immediately.
* The permission to self-administer medication may be revoked by the school staff if it is determined that the student is not safely and effectively self-administering the medication. The medication would then be carried and administered by school staff.

Student Signature: ______________________________ Date: ______________

As parent/guardian of the above-named student, I am responsible for informing school personnel of my student's medical needs. I understand only the prescribed daily dose is to be sent to the school for each day of the field trip.

* Medication must come in the original packaging from the manufacturer or pharmacy. Staff administered medications must be delivered by a parent to the school 5 days prior to the trip.
* Students who self-administer medications are to keep their medications safely with their belongings.
* I acknowledge that The Franklin Academy shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I shall indemnify and hold harmless The Franklin Academy and its employees or agents against any claims arising out of the self-administration of medication by my student.
* This form allows designated school personnel to contact the licensed health care provider listed above regarding health or medication issues.

Parent/Gaurdian Signature: ______________________________ Date: ______________

Licensed Health Care Provider: ____

Licensed Health Care Provider Signature: ______________________ Date: ______________