REQUEST FOR MEDICATION ADMINISTRATION DURING FIELD TRIP

- Please complete one form for each prescribed and/or over-the-counter medication.
- A physician’s signature is required for both prescription and over-the-counter medications.
- Please print this form and deliver it, along with the medication and other permission slips, to the trip chaperone.

I, the parent/guardian of ___________________________________________________________, request that the medication indicated below be administered by a delegate selected by the Head of Division, on the trip to _______________________________________________ on (date/s) _______________________________________________.

1. I understand that a nurse will not be present on the field trip.
2. No students are permitted to self-carry or medicate any prescribed medication and/or over-the-counter (OTC) medication except Epipens and/or inhalers.
3. I will provide the prescribed medication or OTC in the original container labeled with my daughter’s name. The original container will contain the correct number of doses, plus two extra.
4. The delegate will provide a secure location for the prescribed medication or OTC.
5. The delegate will keep a record of the administration of the prescribed medication or OTC.
6. I authorize school employees, including trained non-medical school employees, to administer or assist in the administration to student of the prescribed medication or OTC listed below as ordered by the signing physician.
7. Stuart and its employees shall incur no liability, and I agree to indemnify and hold harmless Stuart and its employees against any claims that may arise, relating to the administration, general supervision, training, or administration in respect of student.

Medication: _____________________________________________________________________________________________________________

Dose: ________________________________________________________ Route:__________________________________________________

Time(s) to administer: ____________________________________ Date(s) to administer: _________________________________

Diagnosis: __________________________________________________

List any possible side effects that might be expected: _______________________________________________________________

_____________________________________________________________  _________________________________
Physician’s Signature                                      Date

_____________________________________________________________  _________________________________
Parent Signature                                            Phone number

_____________________________________________________________  _________________________________
Print Name                                                 Phone Number

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