MEDICATION PERMISSION FORM
FOR EXTENDED DAY/OVERNIGHT FIELD TRIPS

(One form for each medication)

I hereby certify that it is necessary for _____ Date of Birth: _____
(Full Name of Student - List all names used by student)
Teacher/Homeroom: _____ Grade Level:_____
to be given the medication listed below during the school day, including when he/she is away from school property on official school business. Without this medication, he/she will not be able to attend school.

Signed form is necessary for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc.) Only FDA-approved medicines will be accepted.

Name of Medication: _____

Reason for Medication (Diagnosis): _____

Dosage to be given: _____ Route (mouth, injection, etc.): _____

Time(s) of administration: _____ Allergies: _____

Beginning Date: _____ Ending Date: _____ Amount of Liquid or Count of Pills: _____

Emergency Telephone Numbers:

Parent/Guardian: _____ H: _____ W: _____ C: _____

Parent/Guardian: _____ H: _____ W: _____ C: _____

Doctor's Name: _____ Phone:_____

Prescription and non-prescription medication shall come in the original container and shall be labeled. Changes in the medication times or dosage can only be made by written prescription from the physician, which may be faxed to school health personnel. This permission form is valid for the current school year only.

Parents are requested to pick up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded.

I hereby consent to protected health information being used and disclosed to carry out treatment, payment, or health care operations of my child. I understand that the Leon County School District may need to give and receive protected health information pertaining to the management of my child's medical condition with the health care provider listed above, and I hereby authorize the exchange of this information as needed to carry out the treatment, payment or health care operations of my child. I also give permission for the information on this form to be reviewed and utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby authorize the School Board of Leon County, Florida ("LCSB") and Leon County Health Department ("LCHD"), and their officers, employees, contractors and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his or her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration. I hereby release, indemnify, and hold harmless LCSB and LCHD and any of their officers, employees, contractors and agents any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, LCHD and their officers, employees, contractors and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

_____ _____
(Date) (Parent/Guardian Signature)

LEON COUNTY SCHOOLS
MEDICATION ADMINISTRATION LOG
FOR EXTENDED DAY/OVERNIGHT FIELD TRIPS

Student's Name: _____ School: _____

Grade: _____ Chaperone: _____

Reason for Medication/Diagnosis _____

Allergies: _____

Medication: _____ Medicaid # _____

Dosage:_____ Amount: _____ Route_____ Time(s) to be given _____
(mg) (# of pills, tsp, cc, drops) (by mouth, in ear, etc.)

----------BELOW IS FOR THE CHAPERONE TO COMPLETE----------

Date Received (original Rx) _____ #/Amt of Pills/Capsules/Liquid _____ Signature _____

Date Returned (end of year/use) _____ #/Amt of Pills/Capsules/Liquid _____ Signature _____

DATE (Use new line for each date)	TIME/ INITIALS	TIME/ INITIALS	TIME/ INITIALS	TIME/ INITIALS	**SIGNATURE**

Turn form in to school clinic after trip.