8th Grade Cedar Point Trip | Form: 1 | **TURN IN BY APRIL 19th**

Jackson Local Schools

Over-the-Counter Medication Authorization
Field Trip Form (JMMS)

♦DEMOGRAPHIC INFORMATION♦

Student Last Name:	Student First Name:	Student Middle Name:
Street Address:	City:	Zip Code:
School:	Grade:	Birth Date:
Emergency Telephone Number(s):		

Does this student have any allergies to foods or medications? ☐ yes ☐ no

If so, please list: _____

♦OVER-THE-COUNTER MEDICATION♦

The Jackson Local Schools staff members accompanying students on the trip will have the following medications available. Please review the list and **INITIAL** next to the medication that you consent to be administered to your child.

Parent Initial	Medication	Parent Initial	Medication
	Acetaminophen (ex. Tylenol)		Ibuprofen (ex. Advil, Motrin)
	Cough Medication (ex. Robitussin)		Decongestant (ex. Sudafed/Mucinex)
	Antihistamine (ex. Benadryl/Claritin)		Motion Sickness Medication (ex. Bonine)
	Antidiarrheal (ex. Imodium)		Antacids (ex. Tums, Maalox, Mylanta)
	Antibacterial Ointment (ex. Neosporin)		Topical Corticosteroid (ex. Hydrocortisone Cream)
	Cough drops/Throat lozenges		
	If there are other OTC medications that your child might need, please **list them below** and initial the box.(Note: Parent is responsible for providing medication indicated)		

♦PARENT/GUARDIAN AUTHORIZATION♦

Authorization to administer the above listed over-the-counter medication lasts for the duration of the trip only.

With full knowledge of emergencies, dangers, and risks related to the administration of such medication by Jackson Local Schools' district employees, officers, or agents, we the undersigned, hereby waive all claims, which might arise from said administration of such medication to said minor child and the results thereof. We agree to indemnify and hold harmless Jackson Local Schools' employees, officers, or agents, from any and all liability relative to the administration of such medication.

I understand I must submit a revised statement and sign it if any information changes prior to the departure of the trip.

Parent/Guardian Signature:_____ Date:_____

Contact Phone #1:_____ Contact Phone #2:_____

8th Grade Cedar Point Trip

Form: 2

ONLY RETURN IF STUDENT NEEDS PRESCRIPTION MEDICATION DAY OF TRIP

Jackson Local Schools

Prescription Medication Administration Authorization

Student's Name:_____ DOB:_____

Grade:_____ Building:_____ Teacher:_____ School Year:_____

Medication Allergies/Interactions:_____

This form must be completed fully, in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of medication administration.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original packaging with the label intact and contain the student's name**.**
- A parent/guardian **must** bring the medication to school. Students **are not** permitted to bring medication to school.
- The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or child's medication.

♦PRESCRIBER'S AUTHORIZATION♦

(this section must be completed by the prescriber)

Condition for which medication is being administered:_____

Medication:_____ Strength:_____ Dose:_____

Amount:_____ Route:_____ Time:_____ If PRN, frequency:_____

If PRN, for what symptoms:_____

Relevant side effects: □ None expected □ Specify:_____

Medication administration begin date:_____Medication administration end date:_____

**Note: orders are only valid for one school year*

Prescriber's Name/Title:_____Telephone:_____Fax:_____

Address:_____

Prescriber's Signature:_____Date:_____

(Original signature or signature stamp ONLY)

A verbal order was taken by the school nurse, _____ for the above medication on _____

(name) (date)

♦PARENT/GUARDIAN AUTHORIZATION♦

I/We authorize designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that the medication must be in the ***original*** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration when appropriate. I/We understand that at the end of the school year, an adult must pick up the medication; otherwise it will be properly discarded. I/We authorize the school nurse to communicate with the health care provider/prescriber or pharmacist to clarify the above listed medication order as allowed by HIPAA.

Parent/Guardian Signature: _____ Date:_____

Contact Phone #1:_____ Contact Phone #2:_____

Relationship to Student: □ parent □ legal guardian □ other:_____(needs written/verbal permission)

Order reviewed by the school nurse: _____ _____

Signature Date