Holly Area Schools

Field Trip Medication Form

Please fill out one form for each medication to be given on trip

Student Name: _____ **Date of Birth:** _____
School Building: _____ **Grade:** _____ **Field Trip Date:** _____
Parent/Guardian Name: _____ **Phone:** _____
Staff member responsible for medication: _____

Medication Name: _____
Please Check: Daily Scheduled Medication _____ Emergency Medication _____
Dose: _____ Route: _____ Scheduled Time: _____
Is the medication a **controlled substance**: __ Yes __ No **If yes**, how many pills are in the bottle before leaving: _____ How many upon returning: _____
Indication for use if EMERGENCY medication: _____
_____
Potential side effects: _____
Medication can be given 30 minutes before or 30 minutes after the scheduled time.

Administration:
Dose given: __ Yes __ No Date: _____ Time given: _____ am or pm
Medication given without incident? __ Yes __ No
Symptoms present if emergency medication was administered: _____
_____
I maintained the medication in a secure area at all times during the field trip. I documented medication administration on this form and will return it to the school office upon returning to the school. I reported any incidents to the school office/nurse or designated staff. I gave the above medication within the time perimeters allowable by Michigan Law.

Signature: _____ Date: _____
Witness Signature: _____ Date: _____
Emergency medication returned to the office:
__ Yes __ No If not, reason: _____

If student is a diabetic, a paraprofessional or parent/guardian must attend field trip

The following items must accompany this form:

- Completed medication authorization form and/or self carry form, if applicable.
- Medication **must** be in the original container with the student's name.

Person preparing medication for trip:_____ Date:_____
Was medication returned to the office: __ Yes __ No
Signature of whom accepted returned medication: _____ Date: _____
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