# FIELD TRIP OVER-THE-COUNTER MEDICATION AUTHORIZATION

Student Name (Last, First, Middle Initial): _____

Student Address: _____

School of Attendance: _____ Grade: _____

Date of Birth: _____

Emergency Contact Name & Phone Number: _____

Does this Student have any allergies to food or mediations? _____Yes _____ No

If yes, list allergies: _____

_____

Does the Student have an Individualized Healthcare Plan? _____ Yes _____ No

The Stow-Munroe Falls City School District staff members who are accompanying students on your child's field trip will have the following medications available. Please review the list, mark the correct dosage (if applicable), and initial next to the medication that you consent to be administered to your child, if needed.

**For children 12 years of age or older:**

| Medication: | Dosage (circle dosage): | Parent/Guardian Initial: |
|---|---|---|
| Regular Strength Tylenol | 325 mg tablets: 1 tablet (325 mg) | _____ |
| | 2 tablets (650 mg) every 4-6 hours | _____ |
| Regular Strength Ibuprofen | 200 mg tablets: 1 tablet (200 mg) | _____ |
| | 2 tablets (400 mg) every 4-6 hours | _____ |
| Halls Cough Drops | | _____ |
| Regular Strength Tums | 2 chewable tabs | _____ |
| | 4 chewable tabs at onset of symptoms | _____ |
| | (No more than 15 tabs in 24 hours) | |
| Benadryl 25 mg tablet | 1 tablet (25 mg) | _____ |
| | 2 tablets (50 mg) | _____ |
| Dramamine 50 mg tablet* | 1 tablet (50 mg) | _____ |
| | 2 tablets (100 mg) ever 4-6 hours | _____ |
| | *take 30 min before exposure to motion | |

**For children less than 12 years of age:**

| Medication: | Dosage (circle dosage): | Parent/Guardian Initial: |
|---|---|---|
| Junior Strength Ibuprofen 100 mg chewable tabs Every 6-8 hours | 6-8 years old – 2 tabs | _____ |
| | 9-10 years old – 2½ tabs | _____ |
| | 11 years old – 3 tabs | _____ |
| Junior Strength Tylenol 160 mg chewable tabs Every 4 hours | 6-8 years old – 2 tabs | _____ |
| | 9-10 years old – 2½ tabs | _____ |
| | 11 years old – 3 tabs | |
| Halls Cough Drops | | _____ |
| Children's Benadryl 12.5 mg chewable tabs Every 4-6 hours | 1 tab (12.5 mg) | _____ |
| | 2 tabs (25 mg) | _____ |
| Dramamine* 12.5 mg chewable tabs Every 6-8 hours | 1 tab (12.5 mg) | _____ |
| | 2 tabs (25 mg) | _____ |
| | *take 30 min before exposure to motion | |

Authorization to administer the above listed over-the-counter medication(s) extends only for the duration of the field trip.
With full knowledge of emergencies, dangers, and risks related to the administration of the above-authorized over-the-counter medication(s) by the Stow-Munroe Falls City School District City School District Board of Education employees, officers, agents, and/or representatives, the undersigned, for himself/herself and his/her heirs and assigns, in consideration of the Stow-Munroe Falls City School District dispending over-the-counter medication(s), to my child, does hereby release and discharge, covenant not to sue, and agree to indemnify and hold harmless the Stow-Munroe Falls City School District Board of Education, including its officers, members, employees, agents and/or representatives in both their official and individual capacities, for any and all claims, demands, actions, causes of actions or suits at law or equity or whatever kind or nature, whether known or unknown and from a continuing effects therefrom, which might arise out of or relate in any way to the administration of the above-authorized over-the-counter medication(s) to my child/ward and the results thereof. By signing below, I indicate that my child/ward has previously taken the over-the-counter medication I am authorizing the district to administer over-the-counter medications, on an as-needed basis, during the field trip and that my child/ward has not had an adverse reaction to the medication when previously administered.

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

_____ _____

Parent/Guardian Signature Date

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR***

| Clinic Use Only: Date form received: _____ Date medication received: _____ Form Complete (Y or N): ___ |
|---|
| Notes:_____ Date Form Complete: _____ |

7/13/15, 4/11/16, 9/24/18