Northmont City Schools
4001 Old Salem Road
Englewood, Ohio 45322

Administration of Prescription Medication on School Overnight Trip

Since medication for the student named below will be needed during the trip, it is requested that school personnel administer the medication indicated below. *I understand that non-medical school personnel may administer this medication.* **Each medication requires its own separate form. Please make copies as needed.**

***Name of Student**_____ Student Birthdate_____

School Building_____ Grade/Teacher/Team_____

***Name of medication**:_____ **Dose**:_____ **Route**:_____

***Time and frequency to administer medication:**_____

Possible reactions that, if they occur, should be reported to the

physician:_____

*Date the administration of the medication is to begin:_____ and end:_____

***Physician's signature**_____

Physician's address_____

Physician's phone number_____

All medication sent for the trip must be in the original container labeled with the student's name, medication name, and the prescribed dosage. *Each medication must be on a separate form.

Parent/Guardian signature_____ Date_____

Cell phone_____ Daytime phone number_____

***FOR SCHOOL USE:* (Document the time and your initials when a medication is given. If it wasn't documented, it wasn't done)**

Monday Date	**Tuesday** Date	**Wednesday** Date	**Thursday** Date	**Friday** Date	**Saturday** Date	**Sunday** Date
AM	AM	AM	AM	AM	AM	AM
LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
PM	PM	PM	PM	PM	PM	PM
BEDTIME	BEDTIME	BEDTIME	BEDTIME	BEDTIME	BEDTIME	BEDTIME

***School Employee Signature**_____**Initials**_____

Northmont City Schools
4001 Old Salem Road
Englewood, Ohio 45322

Administration of Prescription Medication on School Overnight Trip

Since medication for the student named below will be needed during the trip, it is requested that school personnel administer the medication indicated below. *I understand that non-medical school personnel may administer this medication.* **Each medication requires its own separate form. Please make copies as needed.**

***Name of Student**_____ Student Birthdate_____

School Building_____ Grade/Teacher/Team_____

***Name of medication**:_____ **Dose**:_____ **Route**:_____

***Time and frequency to administer medication:**_____

Possible reactions that, if they occur, should be reported to the

physician:_____

*Date the administration of the medication is to begin:_____ and end:_____

***Physician's signature**_____

Physician's address_____

Physician's phone number_____

All medication sent for the trip must be in the original container labeled with the student's name, medication name, and the prescribed dosage. *Each medication must be on a separate form.

Parent/Guardian signature_____ Date_____

Cell phone_____ Daytime phone number_____

***FOR SCHOOL USE:* (Document the time and your initials when a medication is given. If it wasn't documented, it wasn't done)**

Monday Date	**Tuesday** Date	**Wednesday** Date	**Thursday** Date	**Friday** Date	**Saturday** Date	**Sunday** Date
AM	AM	AM	AM	AM	AM	AM
LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
PM	PM	PM	PM	PM	PM	PM
BEDTIME	BEDTIME	BEDTIME	BEDTIME	BEDTIME	BEDTIME	BEDTIME

***School Employee Signature**_____**Initials**_____