Bentonville Public Schools

Over Night Field Trip Medication Form

Field Trip Location: _____ **Dates of Trip:** _____

Student Name: _____ DOB: _____
Field Teacher: _____ Grade: _____
Parent/Guardian Contact: _____
(Name and Phone Number)
Emergency Contact: _____
(Name and Phone Number)
Off-site location: _____

Medication Name: _____ Treatment of: _____
Exact Dose: _____ Time(s) to be given: _____
Type of Medication: ☐ Pill ☐ Capsule ☐ Inhaler ☐ Liquid ☐ Ointment
Storage: ☐ Room Temp ☐ Refrigerate **Medication Check-in Quantity** _____

Medication Name: _____ Treatment of: _____
Exact Dose: _____ Time(s) to be given: _____
Type of Medication: ☐ Pill ☐ Capsule ☐ Inhaler ☐ Liquid ☐ Ointment
Storage: ☐ Room Temp ☐ Refrigerate **Medication Check-in Quantity** _____

Asthma/Life-Threatening Allergies
*Self-carry Inhaler ☐ Yes ☐ No *Self-carry Epipen ☐ Yes ☐ No (* Inhalers and Epipens are allowed to be self-carried by students if they have a doctor's note or Self-Carry Contract signed by doctor on file.)

Drug Allergies: _____
Side Effects/Adverse Reaction (Include what steps to take if reaction occurs):
_____
_____

Parent/Guardian: I give my permission for this medication to be given during a school field trip by unlicensed persons. I understand that a parent/guardian must deliver medication to school nurse in the original container. (Student cannot bring in medication.)
Signature of Parent/Guardian: _____ Date: _____

Unlicensed Person: I agree to facilitate my student's self-medication in accordance with Arkansas State Board of Nursing Position Statement #97-2 entitled *"Assistance with self-medication for unlicensed persons."* I understand that this permit must be returned to our building nurse following our return to the school building. I have reviewed the Field Trip Medication Procedure Policy.
School Personnel Signature: _____ *Date:* _____
Reviewed by School Nurse: _____ Date: _____

Date	Time Given	Medication/Dose	Route	Instructions	Given By