



MISD

Health Services

### Field Trip/Event Medication Consent

|                   |  |                                       |  |
|-------------------|--|---------------------------------------|--|
| Event             |  | Number of overnight stays             |  |
| Student Name      |  | Allergies                             |  |
| Grade             |  | Homeroom Teacher                      |  |
| Contact phone     |  | Will you be a chaperone?    Yes    No |  |
| Emergency contact |  |                                       |  |

**Please deliver only medications you believe your child will need to the School Nurse or designee before \_\_\_\_\_.**

**Guidelines:**

- All medication MUST be provided by the parent/guardian
- All medication MUST be in the original container clearly labeled with child's name
- Send dispensing cups, syringes, and necessary items along with medication
- Instructions and/or doctor's orders must be included with the medications
- All medication must be picked up by the parent/guardian once the group returns

| Name of Medication | Reason for Medication | Strength (i.e.5mg) | Dosage (i.e. 1 tab) | Time to be administered |
|--------------------|-----------------------|--------------------|---------------------|-------------------------|
|                    |                       |                    |                     |                         |
|                    |                       |                    |                     |                         |
|                    |                       |                    |                     |                         |
|                    |                       |                    |                     |                         |

**Parent/Guardian Consent:**

I am the parent/guardian of the above mentioned student. I hereby acknowledge that I have read and understand the School Board Regulations found on our website, [melissaisd.org](http://melissaisd.org), regarding the administration of medications at school activities. I give permission for the above medication(s) to be administered to my child during out of town school related events by authorized school personnel. My child may self-administer emergency medication according to school guidelines. I understand that the District, the Board, and its employees are not liable for damages or injuries resulting from administration of medication to my child in accordance with Texas Education Code 22.052.

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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| Grade               |  | Homeroom Teacher                      |  |
| Contact phone       |  | Will you be a chaperone?    Yes    No |  |
| Emergency contact   |  |                                       |  |

Scheduled Medication(s) Administration Record:

| Date/Time | Medication | Dose | Signature of Employee |
|-----------|------------|------|-----------------------|
|           |            |      |                       |
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|           |            |      |                       |
|           |            |      |                       |

As Needed Medication(s) Administration Record:

| Date/Time | Medication | Dose | Signature of Employee |
|-----------|------------|------|-----------------------|
|           |            |      |                       |
|           |            |      |                       |
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|           |            |      |                       |

|                |            |
|----------------|------------|
| Designee Name: | Signature: |
| Designee Name: | Signature: |
| Designee Name: | Signature: |