Stanley British Primary School
350 Quebec Street, Denver, CO 80230
Phone: 303-360-0803 Fax: 303-360-0353 Email: stanleybps.org

Permission for Medication for Overnight Field Trips Only

The parent/guardian of _____ ask that school
(Child's name)

staff give the following medication(s) to my child on **overnight field trips**, according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label. **Over the counter medication** must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be **packaged in original container.**

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff trained to administer medication. I further acknowledge that this medication is being given at my expressed request and therefore release Stanley British Primary School, its representatives, and employees from any liability or loss related to the administration of this medicine.

Please sign below for each medication.

Medication: _____ Route _____

Dosage: _____ To be given in school at the following time(s): _____
(Specify exact dosage and amount (i.e. tsp, pills), no ranges please)

If the medication is prn (as needed), please describe symptoms to administer the medication and intervals between doses

_____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

_____
Signature of Health Care Provider with Prescriptive Authority

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Print Name of Health Care Provider

_____
Phone / Fax

Parent/Legal Guardian's Name _____ Parent/Legal Guardian Signature _____ Date _____

Medication: _____ Route _____

Dosage: _____ To be given in school at the following time(s): _____
(Specify exact dosage and amount (i.e. tsp, pills), no ranges please)

If the medication is prn (as needed), please describe symptoms to administer the medication and intervals between doses

_____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

_____
Signature of Health Care Provider with Prescriptive Authority

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Print Name of Health Care Provider _____ Phone / Fax

Parent/Legal Guardian's Name _____ Parent/Legal Guardian Signature _____ Date _____

Medication: _____ Route _____

Dosage: _____ To be given in school at the following time(s): _____
(Specify exact dosage and amount (i.e. tsp, pills), no ranges please)

If the medication is prn (as needed), please describe symptoms to administer the medication and intervals between doses

_____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

_____
Signature of Health Care Provider with Prescriptive Authority

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Print Name of Health Care Provider _____ Phone / Fax

Parent/Legal Guardian's Name _____ Parent/Legal Guardian Signature _____ Date _____

Medication: _____ Route _____

Dosage: _____ To be given in school at the following time(s): _____
(Specify exact dosage and amount (i.e. tsp, pills), no ranges please)

If the medication is prn (as needed), please describe symptoms to administer the medication and intervals between doses

_____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

_____
Signature of Health Care Provider with Prescriptive Authority

---
Print Name of Health Care Provider

_____
Phone / Fax

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

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Medication: _____ Route _____

Dosage: _____ To be given in school at the following time(s): _____
(Specify exact dosage and amount (i.e. tsp, pills), no ranges please)

If the medication is prn (as needed), please describe symptoms to administer the medication and intervals between doses

_____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

_____
Signature of Health Care Provider with Prescriptive Authority

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Print Name of Health Care Provider

_____
Phone / Fax

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date