

Extended Field Trip Medication Form-Middle and High School (Grades 6-12)



Purpose: This form must be completed for every student taking any medication on an extended field trip outside of the regular school day. Medication includes prescription, over the counter and homeopathic/herbal. Please see Jeffco BOE Policy [Administering Medicines to Students](#) for more information.

- This form must be returned to the school nurse at least **1** week prior to departure allowing for necessary review and planning.
- All medications must be checked in to the school nurse **1-2** days prior to departure.
- Please review the parent checklist to make sure all information is complete.

*This form must be **completed by a Medical Provider and signed by a parent/legal guardian.** A Medical Provider must have prescriptive authority in the state of Colorado.*

STUDENT NAME: _____ **DOB:** _____
Health Concerns: _____ **Age:** _____
Allergies: _____

Please provide the following information for each medication to be administered on the trip:

Medication #1: _____
CHECK ONE: As needed ____ Daily ____
TIMES TO BE GIVEN: _____ AM/PM
REASON FOR GIVING: _____
Special Instructions: _____
My child can responsibly carry and self-administer this medication yes no

Medication #2: _____
CHECK ONE: As needed ____ Daily ____
TIMES TO BE GIVEN: _____ AM/PM
REASON FOR GIVING: _____
Special instructions: _____
My child can responsibly carry and self-administer this medication yes no
(Please see page 2 for additional medications)

I approve administration of the above medications as indicated. I understand if an Individualized Student Health Plan (ISHP) is required for a known health condition, it is my responsibility to notify the charter nurse. According to BOE policy JLC and Colorado Nursing Board Policy #30-04, the charter nurse may need to call the physician directly to verify orders.

Parent signature: _____ Date: _____

Medical Provider signature: _____ Date: _____

Charter RN review: _____ Date: _____

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Medication #3: _____

CHECK ONE: As needed ____ Daily ____

TIMES TO BE GIVEN: _____AM/PM

REASON FOR GIVING: _____

Special Instructions: _____

My child can responsibly carry and self-administer this medication yes no

Medication #4: _____

CHECK ONE: As needed ____ Daily ____

TIMES TO BE GIVEN: _____AM/PM

REASON FOR GIVING: _____

Special Instructions: _____

My child can responsibly carry and self-administer this medication yes no

Medication #5: _____

CHECK ONE: As needed ____ Daily ____

TIMES TO BE GIVEN: _____AM/PM

REASON FOR GIVING: _____

Special Instructions: _____

My child can responsibly carry and self-administer this medication yes no