EXTENDED FIELD TRIP OR EXCURSION MEDICATION(S) AUTHORIZATION
(Use as many forms as necessary)

Valid only for field trip or excursion to ______________________________.

EXCEPTION: California Education Code 49423.5 - Specialized services, i.e., EpiPen, diabetes care, nebulizer, etc., may require additional forms and instructions signed by Parent or Legal Guardian and Physician. Request specialized services forms from school.

Please review the **'Notice of Provisions' California Education Code (CEC) Sections 49423, 49423.5, 49480 and California Administrative Code (CAC) Title 5, 18170,** printed on the reverse side of this form.

PARENT OR LEGAL GUARDIAN

Part 1: To be completed by Parent or Legal Guardian

NOTE: All medications must be prescribed, including over-the-counter medications. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of Physician.

I request that designated school personnel assist my child in taking this prescribed medication (including prescribed over-the-counter medication). I agree to, and do hereby hold the District and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this medication. I understand that my child may not have nor take medication during this field trip or extended excursion unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's Physician and counsel school personnel as needed with regard to this medication.

Child's Name ______ M F Sex ______ Birthdate ______ Address ______

Name of School ______ Teacher ______

List all medications routinely taken other than those listed below on this form. ______

I have read and understand the 'Notice of Provisions' printed on the reverse side of this form pertaining to **'Extended Field Trip or Excursion Medication(s) Authorization.'**

Date ______ X **Signature** Parent or Legal Guardian ______ ( ) Home Telephone ______ ( ) Work Telephone ______ ( ) Cell #/Pager # ______

PHYSICIAN

Part 2: To be completed by the Physician

The child named above is under my care. It is necessary for him or her to receive the following medication(s), prescribed and/or over the counter, during the extended field trip or excursion.

Name of medication ______
Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

Name of medication ______
Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

Name of medication ______
Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

Name of medication ______
Diagnosis ______ Dosage (be specific, i.e., milligrams, etc.) ______
Time of day to be given ______ Frequency and indication if 'as needed' ______
Method of administration ______ Duration ______
Precautions or side effects ______
Special instructions, ie. storage/handling ______

X ______ **Signature** Physician ______ Please print name ______ Date ______

( ) ______ Office Telephone