# ***MEDICATIONS FOR SCHOOL TRIPS***

## INSTRUCTIONS

- Packet must be completed for any medication (prescription or over-the-counter) that will be needed during the trip.
- Parent/Guardian completes "Authorization" page
- Physician, Nurse Practitioner, or PA completes the "Certification" page
- All medications need to be in the original container.
- For Prescription medications, limit to the approximate amount needed for the duration of the trip,and leave the rest at home in an alternate container so the properly labeled container is used for the trip.
- Bring completed forms to either health office for review 5 days prior to the trip. Students will be given a written ID card to be packed with their medications.

# JACKSON TOWNSHIP SCHOOL DISTRICT

151 Don Connor Boulevard
Jackson, NJ 08527-3497
(732) 833-4600
FAX (732) 833-4609
www.Jacksonsd.org

**Nicole Pormilli**
Superintendent

**Daniel Baginski**
Assistant Superintendent

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Student:_______________________ School:_________________________

Trip date/s:_____________________ Trip Location:____________________

**Authorization for Self-Administration of Medication On a School Trip**

I, ________________________, parent/guardian of ____________________________
**Print Name** **Name of Student**

herby authorize the Jackson Township Board of Education and its employees to permit my child to self-administer _____________ for the duration of the school trip.
**Name of Medication**

I have also enclosed a written certification from my child's doctor that my child is capable of, and has been instructed in the proper method of self-administration of this medication.

I hereby acknowledge the Jackson Township Board of Education its agents and employees shall incur no liability as a result of any injury arising from the self-administration of this medication. I also agree to indemnify and hold harmless the district and its employees or agents against any claims arising out of self-administration of this medication.

______________________________________________________________________
**Signature of Parent/Guardian** **Date**

**Attachments: Trip Form & Physician Certification**
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Student:_________________________ School:_____________________________

Grade:_ ______________________ Date:______________________

**Certification of Physician**
**Authorization for Student Self-Administration of Medication on a School Trip**

1. I am a licensed physician with offices located at:_________________________
2. I hereby certify that I have treated _____________for____________________
   **Name of Student** **Name of Illness**
3. I also certify that _______________is capable of, and has been instructed in the proper method of self-administration of the following medication for the duration of the school trip.
4. Medication name__________________________________________________
5. Dosage__________________________________________________________
6. Frequency of Administration_________________________________________
7. Side Effects _____________________________________________________

***Please Sign and Stamp with Office Stamp***

______________________________________________________________________
**Signature of Physician/Nurse** **Date**

**Attachments: Trip Form & Physician Certification**
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