HEALTH SERVICES
Prosper Independent School District
Off-Site Activity/Trip Medication Request Form

OFF-SITE ACTIVITY/TRIP

Date of Request: _____**Teacher:** _____ **Activity/Trip:** _____

Student's Name: _____ **Birth date:** _____/_____/_____

Please follow the guidelines below when bringing medication to be administered at an off-site activity/trip:

1. A separate request form is required for each medication.
2. For student safety, all medication should be brought to the clinic by the parent at least 5 school days prior to the activity/trip. All medication must be in an original, properly labeled container and should be provided to the school with only the number of doses that are to be administered during the activity/trip. Prescription medications must be counted by the parent and clinic staff. No medication will be automatically sent from the clinic for overnight trips.
3. All medication will be administered according to the labeled instructions or doctor's orders. Aspirin and aspirin containing products will not be administered without a doctor's order.
4. Medication that is expired will not be given. Medication will be destroyed if not picked up by the parent within 2 weeks following the activity/trip.
5. Nonprescription, homeopathic medication, dietary supplements and herbal supplements will only be given in accordance with Prosper ISD Board Policies FFAC (LEGAL) and FFAC(LOCAL) and District medication guidelines.
6. Campus administration will designate a PISD employee to administer student medications during this activity/trip. This staff member will be responsible for maintaining medications and request forms in a secure location, and for administration and documentation of the medications according to District guidelines. The school nurse will review medication request forms and provide training to the staff member(s) designated for this activity/trip.

   NOTE: If medications are found on the student's person or in his/her belongings that are not accounted for by written request form and are not approved as a self-carry medication by form on file with the school nurse, the student may be subject to disciplinary action.

Medication: _____ **Exp. Date**_____ **Dosage:** _____

Route of administration: ☐ by mouth ☐ inhaled ☐ topical ☐ eye ☐ ear ☐ nasal ☐ injection (circle: IM SQ IV) ☐ rectal ☐ GT/JT

Time to be Administered: _____ **Dates to be Administered:** _____

Condition for which medication is required: _____

Has your child ever taken this medication before? YES NO

Medication Allergies: ☐ No Known Medication Allergies ☐ Allergic to: _____

Special Instructions or known Side Effects of medication on your child: _____

My signature below indicates that I request that PISD staff administer the medication specified above to my child. I agree to release, discharge, and hold harmless the Prosper ISD, Board of Trustees, and/or District employees, and representatives from all claims, demands, actions, and judgements for damages or injuries of any kind resulting from administration of this medication.

I authorize the designated PISD staff to share/obtain my child's health information with the health care provider listed below in order to plan, implement or clarify actions necessary in the administration of school health related services. I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Care Information.

Parent/Guardian Signature: _____ **Email:** _____

Parent's Primary Phone: (_____)_____-_____ **Alternate Phone:** (_____)_____-_____

Physician's Name: _____ **Phone:** (_____)_____-_____

Physician's Signature (if nonprescription medication needed for more than 10 days)**:** _____

Emergency Contacts during hours of this activity/trip:

Name: _____ Relationship: _____Phone: (_____)_____-_____

Name: _____ Relationship: _____Phone: (_____)_____-_____

FOR OFFICE USE ONLY!

☐ PISD Staff Trained

Prescription Medication Count:

Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

Administration Log:

Date	First Time Due:	Second Time Due:	Third Time Due:	Other:
MM/DD	Time Given / Initials	Time Given / Initials	Time Given / Initials	Time Given / Initials

Medication Administration Signatures

Only trained PISD staff may administer student medications unless the student's parent is present and performs the administration

Printed Name	Signature	Initials

I maintained the medications in a secure area at all times during the off-site activity/trip. I complied with all medication administration procedures set forth by the District. I documented medication administration on this medication log. I reported any incidents to the school nurse and completed appropriate documentation. I returned the medications, this log, and the empty bottles to the school nurse.

Designated PISD Employee Signature: _____ Date: _____