	Field Trip Travel Permission		Staff Use Only	
	And Medical Information		Allergies:	
Campus:			 Asthma Inhaler:	
Org			Epi Pen:	
Academic Year: 2023-2024				
Student Name:		Age: _	Male/Female	
-	t, First) Instrument:		(Circle One) Grade:	
Parent/Guardian: Name(s):				
E-mail:				
Full Address: Phone Number(s): Please	e list all where you can be reached)Wk ()			
Emergency Contact:	(Other than parent/guardian.)			
Name:	Relationship:			
Full Address:				
Phone Number(s): H() Wk ()		Cell ()	
	Medical Information	n:		
Doctor's Name:	Phor	ne Numbe	r: ()	
Health Insurance Carrier:				
	Polic			
	Physical History:			
List special medical problems:	(asthma, diabetes, allergies/anaphylaxis	s, seizures	s etc.):	
List any known allergies to foo	d / medications etc:			
Does participant carry medicat	tions on person?(if so please state):			
be administered, on school spo	l condition which requires prescription r onsored trips? Yes / escription Medication Authorization Fo	N		

Permission:

In the event of an injury/illness requiring medical attention, I hereby grant permission to the supervising teacher and/or staff to attend to my son/daughter. If the injury/illness requires further medical attention, I expect every effort will be made to contact me to receive my specific authorization before action is taken. If efforts to contact me are unsuccessful, I grant permission for further necessary medical treatment to be given. In addition, I also give my permission for the supervising teacher and/or staff to transport my child to the physician, dentist, clinic, or to the hospital if an accident or serious illness occurs on the trip and I cannot be located. I understand that treatment will not be delayed in the event I cannot be contacted. I understand and agree that I, and/or my child's other parent(s)/legal guardian(s), am responsible for all medical expenses incurred in treating my child.

Signature of Parent

Date

The information provided on this form will be handled in a confidential manner. Information provided on this form will be shared with staff as necessary to maintain your child's safety.



(Last, First)

Non-Prescriptions/Over-the-counter (OTC) Medication Authorization:

I give Pflugerville ISD representatives, including staff and volunteer chaperones, permission to administer "over-the-counter" medications including, but not limited to, the following medications, at the request of my child. I understand that PfISD personnel will not administer medications if this form is not complete.

DO NOT give consent to staff to administer any non-prescription medication to my student.

_____ I **DO** give consent to staff to administer non-prescription medications to my student as initialed below:

Please *initial all approved* medications that can be administered:

 Ibuprofen
 Acetaminophen
 Antihistamine

 Anti-Diarrheal
 Antacids
 Cough Drops

_____ Antibiotic Ointment (topical for cuts and/or scrapes)

_____Hydrocortisone Cream (for topical itch/rash relief)

Is your child allergic to topical antibiotic ointments? <u>Yes/No</u>

"Over-the-counter" medication NOT to be given to my child include: ______

Parent Signature:_____

Date:_____

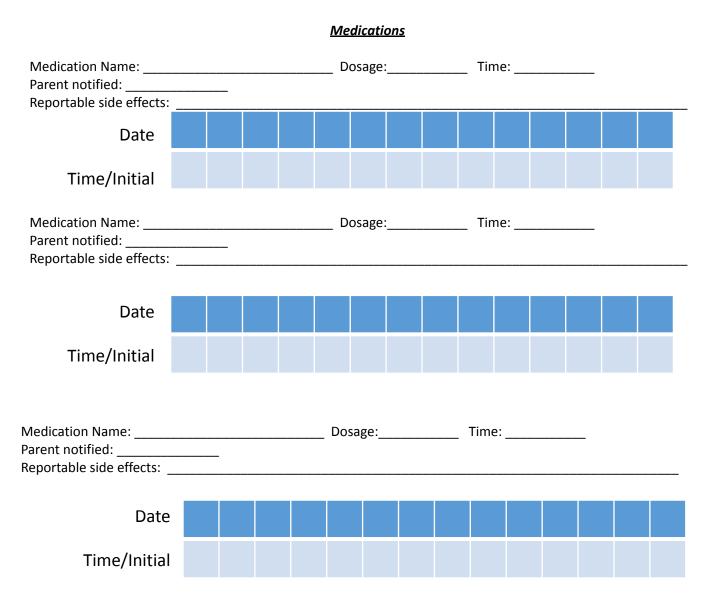


Student Name: _

(Last, First)

Prescription Medication Authorization:

I request that a PfISD representative, including staff administer the following medication to my child according to the physician's instructions while on this field trip. I agree to furnish an adequate amount of medication in the original container at the time of travel. <u>All medications must be in their properly labeled containers with name, dose, frequency of administration clearly noted.</u> Students may only self administer inhalers and epi-pens with the appropriate forms on file with the district, and must be signed by a their physician and prescription labels must be current. As needed (or PRN) medications should have the frequency of repeat doses indicated on the orders. *Expired medications cannot be given.* A second labeled container can be obtained by asking your pharmacist. Attach another sheet of paper if necessary to continue with medications. *The first dose of any new prescription medication must be given at home.*





Medications (cont.)

