MED-10

THE SCHOOL DISTRICT OF GREENVILLE COUNTY

PARENTAL PERMISSION FOR MEDICATION TO BE GIVEN ON A FIELD TRIP

This form and the medication must be given directly to the person administering medication on the trip at least one (1) school day before the trip. All medication must be in the original container, clearly labeled with the student's name. Only the amount of medication needed on the trip should be sent. Physician's written authorization is required for all prescription medication.

STUDENT'S NAME: _____

DATE(S) OF THE TRIP: _____

TIMES OF THE TRIP: _____

DESTINATION: _____

TEACHER IN CHARGE OF THIS TRIP: _____

NAME OF MEDICATION	DOSAGE	TIME TO BE GIVEN

If your child is required by a physician to have this medication on his/her person while on this trip, prior arrangements must be made with the school nurse.

I understand that all medication will be provided by me in the original container, clearly marked with my child's name and given directly to the person in charge of medication administration on this trip. Permission is granted to share this information with other individuals who will have direct responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions.

_____ _____

SIGNATURE OF PARENT DATE

FOR TEACHER'S USE - DO NOT WRITE BELOW THIS LINE

NAME OF MEDICATION	DOSAGE	DATE AND TIME GIVEN	INITIALS

_____

SIGNATURE OF PERSON GIVING MEDICATIONS

_____ _____

SCHOOL DISTRICT POSITION DATE OF TRIP

250-176
Revised 2003

GREENVILLE COUNTY SCHOOLS

Field Trip Permission Slip

My son/daughter _____, has my permission to go with his/her class to _____ on _____. The purpose of this trip is _____. On the date of this field trip, I can be reached at home at telephone number _____ or at work at telephone number _____.

_____ _____
Signature of Parent/Legal Guardian Date

LIMITED POWER OF ATTORNEY

If a serious emergency arises, it may be necessary for a physician to attend your son/daughter before the staff could get in touch with you or your designated physician. Such care can be provided only if you sign the following AUTHORIZATION FOR MEDICAL TREATMENT.

I give the teacher or administrator in charge of my son/daughter limited power of attorney to act in my absence and see that my son/daughter, _____ gets whatever medical treatment is necessary in case of sickness or accident.

List any medical exemptions (allergies, blood transfusion, etc.) for your child.

_____

_____

List any significant health problems.

_____

_____

My child is presently taking the following medicine prescribed by the doctor:

Name of Medicine: _____

Amount Taken: _____

_____ _____
Signature of Parent/Legal Guardian Date

Family Health and Accident Insurance Carrier _____

Policy Number _____

White Copy → Teacher Yellow Copy → School Pink Copy → Parent