IFAS 39502235

EXTENDED DAY AND OVERNIGHT FIELD TRIP AND FOREIGN TRAVEL MEDICATION/TREATMENT ORDER

MUST BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER ONLY IF MEDICATIONS/TREATMENTS ARE REQUIRED ON TRIP

Dear Health Care Provider:

Your patient will be participating in an approved trip to ________________________________
from _____________________ to __________________There will not be a school nurse in
(Date & Time) (Date & Time)
attendance on this trip. If you have any concerns about your patient's health needs on this trip, please contact the nurse at ______________________. **Please indicate below any treatment/prescription and/or over-the-counter medications that your patient is currently taking and will need to continue to take while on the trip. This form must be returned two weeks prior to the trip date to provide for planning and staff training.**

______________________________ _________________________
Student's Name Date of Birth

No medication/treatment can be administered without physician authorization.

To be completed by the Physician

Medication/Treatment	Dosage/Frequency of Administration	Circumstances/symptoms for administration	Diagnosis	Student may carry & self-administer medication. (please check)

Health Care Provider Signature:_____________________ Date:________
Parent Signature: ____________________________ Date: ____________

MEDICATION MUST BE PROVIDED FROM HOME.

To be completed by designated school personnel

Medication/Treatment	Date/Time Medication Given	Date/Time Medication Given	Date/Time Medication Given	Signature of Designated School Personnel