LA CAÑADA UNIFIED SCHOOL DISTRICT

REQUEST FOR MEDICATION TO BE TAKEN DURING VOLUNTARY FIELD TRIP

SECTION I – To be completed and *signed* by parent or guardian

Print Name of Student (Last, First)	Sex (Circle One): Male Female	Birthdate (Month/Day/Year)
☐ **NO PRESCRIPTION OR OVER THE COUNTER MEDICATION REQUESTED** – Check here, sign and return this form.		
☐ **YES, MEDICATION REQUIRED/REQUESTED.** I request that my student (named above) be assisted by authorized persons in taking these described medications while participating in voluntary field trip from (dates) _____to **_____** I understand that all medications will be administered in compliance with the school's policies. **If "YES" is checked your physician must sign below.**		
Signature of Parent or Guardian **X**	Home Telephone Number	Date Signed (Month/Day/Year)

SECTION II - To be completed and *signed* by a Physician (see below)

	Name of Medication	Name of Medication	Name of Medication	Name of Medication
Purpose of Medication				
Dosage Prescribed				
Dose Form (Tablet/Liquid, etc.)				
Time to be Administered				
Precautions, special instructions, possible adverse effect(s), or comments:				

SECTION III To be completed and *signed* by a Physician *if* any medication is requested.

Medication listed below will be available **if authorized by parent and physician, as shown by both required signatures on this form.**
Please indicate your approval for use of these medications by checking the appropriate box before each medication.

YES ☐ NO ☐ Medication & Dose Form: **Tylenol 325 mg. Oral Tablets**
Indications for use: Fever reduction for oral temperature above 101 F.
Relief of headache or minor ache/pain.
Dosage & frequency: One tablet every 4 - 6 hours as needed, not to exceed 5 doses in 24 hours.

YES ☐ NO ☐ Medication & Dose Form: Polysporin
Indication for use: Topical antibiotic to prevent infection in minor cuts or abrasions
Dosage & frequency: Small amount to affected area, applied I - 3 times daily

YES ☐ NO ☐ Medication & Dose Form: Hydrocortisone 1% **Cream**
Indication for use: Relief of itching and pain associated with allergic itches, rashes and insect bites
Dosage and frequency: Small amount to affected area not to exceed more than 4 times daily

Print Name of Physician		The above named student for whom the above medication is prescribed is under my care.
Physician's License Number	Physician's Telephone Number	Signature of Physician
Address (Street, suite/room, city, zip code)		Date Signed (month/day/year)