

LaMuth Middle School
6700 Auburn Road Painesville OH 44077
Phone 440-354-4394 Ext 8504 Fax 440-354-8218
7th Grade Chicago Trip Medication Form

STUDENT'S NAME _____ DATE OF BIRTH _____

Address: _____

Allergy to any food or medication: _____

To anything else (seasonal, animal, stings) _____

Does this student self-carry inhaler? ____ Yes ____ No Is inhaler kept in the clinic? ____ Yes ____ No

Does this student self-carry Epi-Pen? ____ Yes ____ No Is Epi-Pen kept in the clinic? ____ Yes ____ No

Any medication taken on the Chicago trip prescription AND INCLUDING over-the-counter

must have a doctor's signature. Medications taken at home on a daily basis AND over-the-counter that is necessary to take on the trip will be clearly written below and on the medication envelope.

Name of Medication, dose and time to be given.

1. _____

2. _____

Special instructions for administration of medication (storage, with food, etc):

Any possible reactions that, if they occur, should be reported to the physician:

This medication can be safely administered by non-medical personnel ____ Yes ____ No

PHYSICIANS SIGNATURE _____ **Date** _____

PHYSICIANS PHONE NUMBER _____

This medication form is only valid for the Chicago trip May 6-8 2020

Please regard my signature below as my assurance that I release Riverside schools, PSI, and any or all of the school's and PSI officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions and they have been answered to my satisfaction.

PARENT/GUARDIAN SIGNATURE _____ **Date** _____

*****SEE BACK OF FORM*****

Current Medical History _____

Medication your child takes daily _____

Recent illness or injury? _____

Additional information about the student's health in which we may need to be aware of:

TO GRANT CONSENT In the event reasonable attempts to contact me at:

Parent #1 Name _____ Home Phone _____

Work Phone _____ Cell Phone _____

Parent #2 Name _____ Home Phone _____

Work Phone _____ Cell Phone _____

Contacts have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary including Permission to transport my child to the nearest hospital. This authorization does not cover major surgery unless the medical opinion of Two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Doctors Name _____ Phone _____

Dentist Name _____ Phone _____

Or, in the event the designated practitioner is not available, by another licensed physician or dentist.

SIGNATURE OF PARENT/GUARDIAN

Address- IF DIFFERENT FROM STUDENT
