Pride of Bixby Trip Medication Form

Student Name:_____

Student Cell Number:_____

Parent/Guardian Name:_____

Parent/Guardian Cell Number:_____**Insurance Carrier:**_____

Policy#:_____**Group Number:**_____

Responsible Party:_____

Medications:

This signed and completed form must be turned into the trip nurse at time/date specified prior to trip. Include any medications that will need to be taken on this overnight trip. We will have a stock of typical over-the-counter medications, that you have already consented to, available during the trip. All medications MUST be in original bottles. Prescription medications must include the pharmacy label with student name, physician name, expiration date, and dosage instructions. Over-the-counter medications must include manufacturer instructions. All medications should be placed in a clear zip lock bag labeled with the student's name. Parents/guardians traveling with the band may dispense medications to their child only. **Members that do NOT have a parent /guardian traveling with the band, MUST turn in medications to be dispensed by the trip nurse and/or band representative. ALL medications must be provided to the designated Band Nurse - First Aid or Designated Band Director prior to boarding the bus.** Medications will be distributed, as prescribed, at a designated time and location to be determined once the trip schedule is posted. Once the location and times are determined, a notification through BAND APP will be sent to students needing medications. Medications will be held and distributed as prescribed or as necessary by the trip nurse until departure from _____. Medications not picked up upon return will be disposed of properly. Students who have rescue inhalers, epi-pens, or emergency meds may keep them on their persons, however, such medications and purposes should be noted on the list below.

Student Allergies (meds, foods, environmental, etc)	Reaction to Medications

Does the student require an epi-pen for any of the above allergies?

_____Yes

_____No

Pride of Bixby Trip Medication Form

Student Name:_____

Medication (name and strength)/Reason for use (diagnosis)	Dose/ Frequency	Time to be given

Are there any specific side effects to expect or report?
_____Yes
_____No

If yes, please name the medication and explain:_____

I,_____, parent/legal guardian of the above named student, have read, understood, and agree to the above administration of medications to my child and have included this information on my child's Band Registration. By signing below, I also acknowledge consent for my child to receive medical treatment. If a simple medical problem arises, I hereby grant the trip sponsors, or a trained first aid provider, the authority to administer simple medications/first aid while on this trip. In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment necessary by a licensed healthcare provider; and (2) the transfer of the child to any hospital reasonably accessible. I further understand, I will take full financial responsibility for all expenses, which might be incurred for medical issues beyond simple first aid.

Guardian Signature:_____Date: _____

Trip Band Nurse-First Aid: Susan Roach cell: 918-361-2809 email: smroach1979@yahoo.com