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 (MM/DD/YYYY)
☐ 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 to for ALL CHORAL EVENTS 2022-2023. 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. Each box must have a yes or no checked!

YES	NO		
YES ☐	NO ☐	Medication & Dose Form: Indications for use: Dosage & frequency:	Tylenol Junior Strength 160 mg. Melt away Oral Tablets Fever reduction for oral temperature above 101 F. Relief of headache or minor ache/pain. Two tablets every 4 - 6 hours as needed, not to exceed 5 doses in 24 hours
YES ☐	NO ☐	Medication & Dose Form: Indications for use: Dosage & frequency:	Polysporin Topical antibiotic to prevent infection in minor cuts or abrasions Small amount to affected area, applied 1 - 3 times daily
YES ☐	NO ☐	Medication & Dose Form: Indications for use: Dosage & frequency:	Hydrocortisone 1% Cream Relief of itching and pain associated with allergic itches, rashes and insect bites Small amount to affected area not to exceed more than 4 times daily
YES ☐	NO ☐	Medication & Dose Form: Indications for use: Dosage & frequency:	Diphenhydramine Hydrochloride Antihistamine Liquid (12.5 mg per teaspoon) Allergies/Allergic reactions 1 to 2 teaspoons every 4-6 hours as needed. Not to exceed 6 doses in 24 hours

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 X
Address (Street, suite/room, city, zip code)		Date Signed (month/day/year)