Twinsburg City School District

11136 Ravenna Road
Twinsburg, OH 44087
330.486.2000

❑ Twinsburg High School	330.486.2400	❑ Samuel Bissell Elementary School	330.486.2100
❑ RB Chamberlin Middle School	330.486.2281	❑ Wilcox Primary School	330.486.2030
❑ George G. Dodge Intermediate School	330.486.2200		

EXTENDED FIELD TRIP MEDICATION ADMINISTRATION FORM

STUDENT NAME: ____DATE OF BIRTH: ________________________

I request and give consent to a volunteer chaperone/teacher/nurse that has been authorized by the Twinsburg City School District, to administer the medication(s) listed below to my child. **I will provide medication in accordance with the Twinsburg City School District's Field Trip Medication Policy (attached).** I further agree to hold harmless the Board of Education, all school employees, and volunteers from any and all liability for damages or injury caused by the administration; of medication to my child.

I have **provided** the following ***prescribed Daily medication(s)*** listed below and my student should receive them on the extended field trip only. This authorization will be revoked upon completion of the trip. ***(Please note that a medical practitioner's signature IS required if prescriptive medication will be administered to your child during the trip.)***

Medication	Dose	Time to Administer	Purpose of Medication

Medical Practitioner's Signature ____ Date: _________________

Medical Practitioner's Name (Printed) ____ Phone: ________________

I have **provided** the following **over-the-counter medications**, and my signature authorizes administration to my child in the event she/he experiences symptoms listed.

This authorization will be revoked upon completion of the trip. I further agree to hold harmless the Board of Education, all school employees and volunteers from any and all liability for damages or injury caused by the administration of medication to my child. ***(Please note that a medical practitioner's signature is NOT required for the administration of NON-prescriptive medications.)***

Medication Brand	Dosage	Administer	Purpose of Medication

Parent/Guardian Signature ____ Date: ___________________

Parent/Guardian Name (Printed) ____ Phone: __________________

☐ Check this box if your child currently has the above medication in the school clinic and are requesting that we utilize that medication for the field trip. (i.e. EPiPen). Please note that this form must be completed in its entirety according to the Field Trip Medication Policy.