



**HEALTH SERVICES**  
 Prosper Independent School District  
**Off-Site Activity/Trip Medication Request Form**

**OFF-SITE ACTIVITY/TRIP**

**Date of Request:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Activity/Trip:** \_\_\_\_\_

**Student's Name:** \_\_\_\_\_ **Birth date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Please follow the guidelines below when bringing medication to be administered at an off-site activity/trip:

1. A separate request form is required for each medication.
2. For student safety, all medication should be brought to the clinic by the parent at least 5 school days prior to the activity/trip. All medication must be in an original, properly labeled container and should be provided to the school with only the number of doses that are to be administered during the activity/trip. Prescription medications must be counted by the parent and clinic staff. No medication will be automatically sent from the clinic for overnight trips.
3. All medication will be administered according to the labeled instructions or doctor's orders. Aspirin and aspirin containing products will not be administered without a doctor's order.
4. Medication that is expired will not be given. Medication will be destroyed if not picked up by the parent within 2 weeks following the activity/trip.
5. Nonprescription, homeopathic medication, dietary supplements and herbal supplements will only be given in accordance with Prosper ISD Board Policies FFAC (LEGAL) and FFAC(LOCAL) and District medication guidelines.
6. Campus administration will designate a PISD employee to administer student medications during this activity/trip. This staff member will be responsible for maintaining medications and request forms in a secure location, and for administration and documentation of the medications according to District guidelines. The school nurse will review medication request forms and provide training to the staff member(s) designated for this activity/trip.

**NOTE:** If medications are found on the student's person or in his/her belongings that are not accounted for by written request form and are not approved as a self-carry medication by form on file with the school nurse, the student may be subject to disciplinary action.

**Medication:** \_\_\_\_\_ **Exp. Date** \_\_\_\_\_ **Dosage:** \_\_\_\_\_

**Route of administration:**  by mouth  inhaled  topical  eye  ear  nasal  injection (circle: IM SQ IV)  rectal  GT/JT

**Time to be Administered:** \_\_\_\_\_ **Dates to be Administered:** \_\_\_\_\_

**Condition for which medication is required:** \_\_\_\_\_

**Has your child ever taken this medication before? YES NO**

**Medication Allergies:**  No Known Medication Allergies  Allergic to: \_\_\_\_\_

**Special Instructions or known Side Effects of medication on your child:** \_\_\_\_\_

My signature below indicates that I request that PISD staff administer the medication specified above to my child. I acknowledge that I will not hold the Prosper ISD, Board of Trustees, and/or District employees liable for damages or injuries resulting from administration of this medication.

I authorize the designated PISD staff to share/obtain my child's health information with the health care provider listed below in order to plan, implement or clarify actions necessary in the administration of school health related services. I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Care Information.

**Parent/Guardian Signature:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Parent's Primary Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Alternate Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Physician's Signature** (if nonprescription medication needed for more than 10 days): \_\_\_\_\_

Emergency Contacts during hours of this activity/trip:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

