Medication Administration Log for School-Sponsored Overnight Events

Student Name: _____ Date of Birth: _____

Event Description: _____ Dates: _____

Medication(s): _____

Medication Dosage: _____ Time(s) to be given: _____

Day(s) to be given: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

I, _____, request and give permission for school personnel at Dripping Springs High School to give my child, _____, the following medication according to the stated directions. I understand and agree that the school will not be held responsible for any ill effects which might occur in connection with the administration of this medication.

Parent/guardian signature:_____ Date: _____

A physician's signature is required on this form for all controlled substance medicine (ex. ADHD medicine) and be in the original container. If a student has a medication permission form on file for 2021-22 school year with a physician's signature, a new form is not needed. Please limit the amount of medication needed for trip.

Physician signature: _____ Date: _____

Physician Name (please print):_____ Phone number: _____

Medication Count:

Date received:
Amount received:

DSISD RN signature: _____

Witness signature: _____

Record of Administration

Date	Time / Initials	Signature	Date	Time / Initials	Signature