Green Local Schools

GMS Washington DC Trip ~~ Oct 18th – Oct 21st, 2023

Over the Counter Medication Form

Students Name: ____

First Middle Last

Students Date of Birth: _________________

Allergies: ____

Medical Concerns while on trip:

____

Listed below are the stock medications that staff/nurse will be carrying. Please indicate if your student can receive these medications with a checkmark.

Advil 200mg = 1-2 tabs every 6 hours		**Mylanta Chewable 1-2 tablets for upset stomach**	
Tylenol 325 mg= 1-2 tablets every 4 hours		**Robitussin DM cough syrup for cough (Adult formula) as directed**	
Imodium AD 2mg = 1-2 tablets as directed for diarrhea		**Benadryl 25mg = 1 tablet every 4 hours as needed for allergy symptoms**	
Neosporin ointment for cuts and abrasions		**Dramamine 50 mg 1-2 tabs every 4 hours as needed**	

My child has permission to be given mediations which I have checked above, according to the recommended dose on the label. Medications will be administered only on a per need basis.

Parent Signature: ______________________________ Date: _______________

Green Local Schools

STUDENT PRESCRIPTION MEDICATION REQUEST FORM

EVENT: GMS Washington DC Trip **TRIP DATE: Oct 18th- Oct 21, 2023**

STUDENT NAME: ______________________________ **DATE OF BIRTH: _______________**

***All prescribed medications must be brought in the container in which they were issued with the student name, prescription number, dosing orders, and physician name intact on label.**

****** THIS FORM IS TO BE COMPLETED AND SIGNED BY THE PHYSICIAN IF PRESCRIPTION MEDICATION(S) ARE TO BE ADMINISTERED.

LIST OF MEDICATIONS

1. ____

   Dosage and times to be administered: ______________________________
   Possible side effects to watch for: ________________________________
   Storage of medication: ____
   Instructions for administration: ___________________________________

2. ____

   Dosage and times to be administered: ______________________________
   Possible side effects to watch for: ________________________________
   Storage of medication: ____
   Instructions for administration: ___________________________________

3. ____

   Dosage and times to be administered: ______________________________
   Possible side effects to watch for: ________________________________
   Storage of medication: ____
   Instructions for administration: ___________________________________

______________________________ ______________________________

Physician's Name Printed **Physician's Signature**

Physician's Phone Number: (_______) _________________________ **Date: ______________________**

Parent/Guardian Signature: _________________________________ **Date: ______________________**