SkillsUSA
PENNSYLVANIA

District 2
MEDICATION ADMINISTRATION FORM

- This form is required only for students who will need medication administered on this trip
- All medication, both prescription and non-prescription, must be kept with the SkillsUSA District 2 nurse with the exception of Epi-Pens, inhalers, and insulin.
- All medication to be administered while on a SkillsUSA sponsored trip is required to be accompanied by a medication order from the prescribing healthcare provider.
- No medication shall be administered to any student without proper completion of this SkillsUSA District 2 Medication Dispensing Form.
- The term "medication" includes prescription drugs as well as over-the-counter medications, vitamins, and supplements.
- Completion of the form includes signatures of both the parent/guardian and healthcare provider.
- A separate form is needed for each medication and must include the dosage, time to be administered, and any other special instructions.
- All medication must be in the original, properly labeled prescription bottle or packaging.
- Only the necessary doses of medication needed for the duration of the trip or event should be sent with the student.
- All medications should be placed into a Ziploc bag clearly labeled with the student's name and school.

TO BE COMPLETED BY THE HEALTHCARE PROVIDER:

Student's Name:_____ Age:_____Grade:_____ School:_____

Name of Medication:_____ Dosage:_____ Time:_____

Special Considerations:_____

Reason for Medication:_____ Effective Date From:_____ To:_____

I certify that I am the healthcare provider who prescribed the treatment and that the above student is under my supervision as a patient.
Signature of Physician/Dentist:_____ Printed Name:_____

Address:_____

Phone number:_____ Fax:_____ Date:_____

TO BE COMPLETED BY PARENT/GUARDIAN

As parent/guardian of the above named student, I herby request that the treatment described above be administered to my child and release the staff of SkillsUSA and it's employees from liability for any damages my child may suffer as a result of the request.

Signature of Parent/Guardian:_____ Date:_____
Cell:_____ Work:_____

Spaces for Additional Medications on Back Side

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ADDITIONAL MEDICATIONS:

Student's Name:_____

TO BE COMPLETED BY THE HEALTHCARE PROVIDER:

Name of Medication:_____ Dosage:_____ Time:_____

Special Considerations:_____

Reason for Medication:_____ Effective Date From:_____ To:_____

Name of Medication:_____ Dosage:_____ Time:_____

Special Considerations:_____

Reason for Medication:_____ Effective Date From:_____ To:_____

Name of Medication:_____ Dosage:_____ Time:_____

Special Considerations:_____

Reason for Medication:_____ Effective Date From:_____ To:_____

Name of Medication:_____ Dosage:_____ Time:_____

Special Considerations:_____

Reason for Medication:_____ Effective Date From:_____ To:_____

TO BE COMPLETED BY THE HEALTHCARE PROVIDER:

I certify that I am the healthcare provider who prescribed the treatment and that the above student is under my supervision as a patient.

Signature of Physician/Dentist:_____ Printed Name:_____

Address:_____

Phone number:_____ Fax:_____ Date:_____

TO BE COMPLETED BY PARENT/GUARDIAN

As parent/guardian of the above named student, I herby request that the treatment described above be administered to my child and release the staff of SkillsUSA and it's employees from liability for any damages my child may suffer as a result of the request.

Signature of Parent/Guardian:_____ Date:_____

Cell:_____ Work:_____