SkillsUSA District 2
Medication Information Form
Overnight Trips

1. Please list **ALL MEDICATIONS** on the forms provided.

2. **ALL MEDICATIONS** (prescription & over-the-counter) must be accompanied by the healthcare provider's authorization and in the **ORIGINAL** pharmacy container.

3. Over-the counter medications (medications that are bought off the pharmacy shelf) must be sent in the original store packaging AND accompanied by a healthcare provider's authorization.

4. **ALL MEDICATIONS (prescription and over-the-counter) should be brought to the advisor at the start of the trip** (before departure). Please pack meds in a clear ziploc-type bag, clearly labeled with the student's name.

5. The Trip Nurse will have acetaminophen, ibuprofen, diphenhydramine (Benadryl), and Mylanta for **emergency use** only. Should a student require these medications routinely, they must be supplied by the student as noted in #3.

Medication	**Action Required**	**Administration**
Prescribed Medications	Doctor's Authorization Pharmacy Packaging	Nurse administers
Oral Contraceptives	Doctor's Authorization Pharmacy Packaging	Student administers
Rescue Inhaler	Doctor's Authorization Pharmacy Packaging	Student administers
Epi-Pens	Doctor's Authorization Pharmacy Packaging	Student may carry
Insulin	Call Nurses' Office for information	
Over-the-Counter Medications	Doctor's Authorization Pharmacy Packaging	Nurse Administers
Migraine Medication	Doctor's Authorization Pharmacy Packaging	Nurse Administers

SkillsUSA District 2
Medication Administration and Authorization Form
Overnight Trips

Student Name: _____School: _____

Please list all **Student Health Conditions** (Including Allergies):

_____

_____

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_____

PHYSICIAN'S AUTHORIZATION FOR MEDICATION ADMINISTRATION:
Please complete the following section if student requires any medication. You should list **ALL Prescription and Over-the-Counter Medications** that they will need over the course of this trip - including prescription creams or lotions. Over-the-counter medications also require a physician's authorization for administration.

Please Note: **This section must be signed off on by your physician at the bottom of this page.**

If no medication is required, please indicate by writing N/A on the lines provided.

Name of Medication Dose How Often/Time(s) Medication(s) attach sheet if necessary

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Physician's Name _____

Physician's Signature _____