

**BETHLEHEM AREA SCHOOL DISTRICT**  
**Bethlehem, Pennsylvania**

**Authorization Form For Self Medication For Overnight Trips – High School Only**  
**(to be completed by parents/guardians)**

Dear Parent or Guardian,

You have indicated that your child requires the administration of medication(s) during an overnight educational trip/activity. It is recognized that some students may have unique medical needs, and there may be instances in which medication will be required during an overnight school trip/activity. Administration of medication (including self-administration) is only required where one or more of the following criteria are met:

- a. The student’s physician has certified, in writing, that failure to take the medication would pose a health risk to the student;
- b. The medication has been deemed to be a reasonable disability-related accommodation pursuant to the student’s Section 504 plan or IEP; and/or
- c. The student’s physician has certified, in writing, that the student would be unable to participate in the program without the medication.

In circumstances other than those referenced above, the school nurse will make a determination as to whether a particular medication will be permitted to be administered on an overnight field trip.

Your child’s medication will be administered pursuant to the information, below. Please sign this document and return it along with the required Certification/Order from your child’s licensed healthcare provider to the school nurse by \_\_\_\_\_. If you have any questions, please feel free to contact the school nurse.

The District will proceed as follows with regard to the administration of your child’s medication on the **[INSERT NAME OF EDUCATIONAL TRIP/ACTIVITY]**, which will take place on **[INSERT DATE(S) OF TRIP/ACTIVITY]**.

**POSSESSION OF MEDICATION**

The Student  **IS** permitted to **POSSESS/CARRY** the medication during the trip. Such medication must be maintained by the student in a secure location. Misuse of medication or provision of medication to other individuals shall result in discipline and may result in the student’s removal from the trip/activity.

The Student  **IS NOT** permitted to **POSSESS/CARRY** the medication during the trip. The medication will be **MAINTAINED** by:

- Nurse
- Parent

**ADMINISTRATION OF MEDICATION**

Medication will be **ADMINISTERED** by:

- Student Self-Administration (Nurse: complete “Self-Administration” section, below)
- Nurse
- Parent

**SELF-ADMINISTRATION**

This student **is authorized** to self-administer his/her medication during the educational trip/activity on \_\_\_\_\_. Note that the medication(s) identified in the attached Certification/Order must be presented to a school nurse prior to the beginning of the trip. Such medication must be provided in the original container with a valid expiration date. Only the amount of medication necessary for the trip should be supplied (an extra dose may be provided if the Parent or School Nurse feels that it would be prudent to do so).

Self-administration **is not permitted** for this student. Reason: \_\_\_\_\_.

The school nurse has determined that this student is not permitted to self-administer. Please contact the school nurse for more details regarding this decision.

**Name of Medication(s)** (*attach additional sheet, if necessary*)

Medication(s)	Dosage Amount	Reason for Medication(s)	Hour(s) or Time(s) to be Dispensed

*Check here if additional sheet is attached*

**Effective Dates (current school year only):** From \_\_\_\_\_ To \_\_\_\_\_

**PARENT CERTIFICATIONS**

**By signing below, I certify that:**

- I am the lawful parent/legal guardian of this student.
- The above chart accurately reflects the medication(s) being taken by my child.
- I agree with the above-identified information and procedures for administering medication to my child.
- Administration, self-administration, or possession of medication that is not medically necessary and/or does not meet the requirements set forth in Board Policy 210 – Administration of Medications shall not be permitted.
- I understand that any/all use and/or possession of medications by a student on school grounds or during a school-sponsored trip must comply with Board Policy 210 – Administration of Medications unless otherwise specified in my child’s IEP or Section 504 plan.
- I understand that if my child is found to be in possession of medication that he/she has not been pre-approved to possess, pursuant to Board Policy 210 – Administration of Medications, such possession shall be considered a violation of board policy. I understand that students authorized to self-administer and/or carry medication assume full responsibility for appropriately securing the approved medication(s) and any improper use and/or distribution will result in disciplinary action.

*(Where Parent will be attending the trip and has volunteered to administer the child's medication):*

- I acknowledge that I have volunteered to administer my child's medication on this trip. I recognize that the District would make arrangements to ensure effective administration of my child's medication in the event that I had not volunteered. I further recognize that, in the event that I am not able to attend the trip, I need provide the District with as much notice as possible, so that the District can make alternate arrangements for the administration of medication. In the event that I am not able to provide at least 48 hours' notice of my non-attendance, and, as a result, the District is unable to make alternate medication administration arrangements for my child and/or unable to obtain the necessary approvals and certifications for self-administration, the District may be required to prohibit my child from attending due to medical concerns.
- I will indemnify and hold harmless the Bethlehem Area School District, including its Board of School Directors, employees and agents, against any claims arising out of the administration or self-administration of medication pursuant to this Authorization.

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**SIGNATURES**


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\_\_\_\_\_  
Parent/Guardian – Print Name Legibly

\_\_\_\_\_  
Parent/Guardian – Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student – Print Name Legibly

\_\_\_\_\_  
Student – Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Nurse – Print Name Legibly

\_\_\_\_\_  
School Nurse - Signature

\_\_\_\_\_  
Date

School Nurse Signature

Date

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