University School of Milwaukee Trip Medication Information & Consent Form (Updated 01/21/2020)

Date: ____________________ **Trip Name**: ___________________________

Student's Name: ___________________________ **D.O.B.:** ___________ **Grade:** ________

See Magnus Health for all school <u>stocked over the counter</u> medication.

______ My student does not need any additional medications during this trip. (Please Initial & sign below if this pertains to your child.)

OTC & Prescription Trip Medications:

All names of medications must match that on the prescription bottle or OTC bottle. The dosage and instructions for prescription medication must match that on the bottle. The OTC medication will be given as directed in the packaging.

If you have ANY PRESCRIPTION MEDICATION YOU MUST HAVE THE DOCTOR'S SIGNATURE BELOW. This can be faxed into the school clinic if needed at 414-540-3121. If you have questions, please call the clinic at 414-540-3120.

1. Medication: ___________________
   Dosage: ______________________
   Route: _______________________
   Time Given: ___________________
   Reason: ______________________

2. Medication: ___________________
   Dosage: ______________________
   Route: _______________________
   Time Given: ___________________
   Reason: ______________________

3. Medication: ___________________
   Dosage: ______________________
   Route: _______________________
   Time Given: ___________________
   Reason: ______________________

4. Medication: ___________________
   Dosage: ______________________
   Route: _______________________
   Time Given: ___________________
   Reason: ______________________

5. Medication: ___________________
   Dosage: ______________________
   Route: _______________________
   Time Given: ___________________
   Reason: ______________________

6. Medication: ___________________
   Dosage: ______________________
   Route: _______________________
   Time Given: ___________________
   Reason: ______________________

Only for Upper School Student Overnight Trips

______ Initial if this student is able to carry and self-administer their Asthma Inhaler / EpiPen and other medications on this trip. The student is capable of proper method of self-administration and is aware of the dangers of improper use or the permitting of other persons to use these medications. If necessary, any of these medications can be administered by a trained USM employee. USM reserves the right for a faculty person to carry and administer these medications if deemed to be in the best interest of the student and those present as a result of behavioral issues or mismanagement of their medication.

*** Parent signature is required.**

*Parent Signature: ____ Date: ______________

****Physician Signature is required for all prescription medications.**

**Physician's Signature: _____________________________________ Date: ______________

Physician's Phone Number: _______________________ **School Clinic Fax 414-540-3121**