MASCONOMET REGIONAL SCHOOL DISTRICT
Medication Administration Plan – DC Field Trip

Name of Student_____ Date of Birth_____ Grade 8

Parent/Guardian Name_____Home telephone_____

Business telephone_____ Cell Phone_____

Food/drug Allergies_____
(if not a violation of confidentiality)

Name of Medication:_____

Name of Licensed Prescriber:_____

Date Ordered – refer to doctor's medication order

Duration of Order: one year from date ordered

Dosage – refer to doctor's medication order

Frequency- refer to doctor's medication order

Route of Administration – refer to doctor's medication order

Special considerations: _____

Possible Side Effects/Adverse Reactions: Refer to doctor's medication order

My child will self-administer an **inhaler, insulin, epinephrine auto-injector, and/or pancreatic enzymes**: Yes or No

Delegated to (if applicable): Rebecca Calzini/designated Washington DC chaperone

Other persons to be notified of medication administration if applicable (with parental permission): Rebecca Calzini/Designated Washington DC Chaperone

Other medications being taken by the student (if not in violation of confidentiality):

_____

Location where medication administration will occur: Washington DC Field Trip Oct. 22-25, 2024

Parent/Guardian Signature_____ Date_____

Student's Signature (**if** self-administering an **inhaler, insulin, epinephrine auto-injector, and/or pancreatic enzymes**):

_____ Date_____

Filled in at medication drop off:

Expiration Date of Medications on Bottle: _____

Quantity of Medication Received by School: _____ Date Medication Received by School:_____

School Nurse Signature _____Date_____