

**EXTENDED DAY AND OVERNIGHT FIELD TRIP AND FOREIGN TRAVEL
MEDICATION/TREATMENT ORDER**

THIS SIDE TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Dear Health Care Provider:

Your patient will be participating in an approved trip to _____ from _____ to _____. There will not be a nurse in attendance (date and time) (date and time) on this trip. If you have any concerns about your patient’s health needs on this trip, please contact the cluster nurse at _____. **Please indicate below any treatment/prescription and/or over-the-counter medications that your patient is currently taking and will need to continue to take while on the trip.** This form must be returned two weeks prior to the trip date to provide for planning and staff training.

Student’s Name

Date of Birth

To be completed by the Physician

Medication/Treatment	Dosage/Frequency of Administration	Circumstances/symptoms for administration	Diagnosis

_____ Student may carry and self-administer medication.

Signed by prescribing health care provider: _____

Date: _____

To be completed by designated school personnel

Medication/Treatment	Date/Time Medication Given	Date/Time Medication Given	Date/Time Medication Given	Signature of Designated School Personnel