Medication Administration Log for School-Sponsored Weekend/Overnight Events

Student Name: _____	Date of Birth: _____
Event Description: _____	Dates: _____
Medication(s): _____	
Medication Dosage: _____	Time(s) to be given: _____

Day(s) to be given: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

I, _____, request and give permission for school personnel or chaperones from Dripping Springs ISD to give my child, _____ the above medication, in its **original container**, according to the stated directions. I understand and agree that the school will not be held responsible for any ill effects which might occur in connection with the administration of this medication. **Please limit the amount of medication to only what is needed for the trip.**

Parent/guardian signature:_____ ___ Date: _____

A physician's signature is required on this form for all controlled substance medicine (ex. ADHD medicine) and in its **original container**. If a student has a medication permission form on file for the current school year with a physician's signature, a new form is not needed.

Physician signature: _____ Date_____

Physician Name (please print):_____ Phone number: _____

Medication Count:

Date received:	DSISD Nurse signature: _____
Amount received:	Witness signature: _____

Record of Administration:

Date	Time/ Initials	Signature	Date	Time/ Initials	Signature

Medication Trained Designee Signature:_____