Student Name:___________________________ First Period Teacher:________________________

SCIS Medical Information Form

Perot Museum Sleepover February 7, 2014

DUE: WEDNESDAY JANUARY 8th

Note: Proper collection and distribution of medication while attending the Perot Museum sleepover is extremely important to us at Sloan Creek. The included information on this form is required for each student attending the trip. Please take a moment to complete this information for our nurse, who is attending with us, and return it to your child's first period teacher by **Wednesday, January 8th.**

Medication Reminders and Requirements:

- All medication must be in the original containers. Pharmacist label must be attached if it is a prescription.
- No expired medications will be accepted.
- Only emergency asthma inhalers accompanied by a "self-carry" signature on the asthma action plan will be allowed with the student.
- Only the LISD staff Nurse may dispense medication: Parent volunteers may not dispense medication.
- All medications must be delivered to the Sloan Creek Nurse by **Wednesday, January 29th**. Place medication in the original container in a 1 gallon ziplock bag with student's name written on the bag. Please do not send any medication with students to school. A parent must deliver all medications to the school nurse.
- School personnel may not dispense non-FDA approved medications such as vitamins or supplements.
- Only send the amount of medication needed for the trip.
- Please send medications by the deadline, so it can be properly stored and recorded for transporting to the museum. Thanks in advance for your help with this!

Allergies:

Please list any food, medication, or environmental allergies:	

Please make arrangements with the nurse for any special dietary needs.

Over the Counter and Prescription Medications:

Please list in detail any over-the-counter or prescription medications that you will be providing for your child during the sleepover. We cannot administer any medication if it is not provided from home:

OTC Medication	Special Instructions

Daily prescription medications that must be administered-Indicate dosage and frequency for each medication:

Medicine Name	**Rx No:**	**Check box for time to administer:**		**Special Instructions**
	Dosage:	**Friday**	**Saturday**	
	After Dinner			
	At Breakfast			

Medicine Name	**Rx No:**	**Check box for time to administer:**		**Special Instructions**
	Dosage:	**Friday**	**Saturday**	
	After Dinner			
	At Breakfast			

Date Medication Returned: __________________

Nurse's Signature: __________________________

____

Parent Signature