MIDLAND INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT

Permission for Student to Carry and Self-Administer

ORAL CONTRACEPTIVE (Birth Control) for Overnight School Trip

Student Name: ______________________________ DOB: ____________

Homeroom Teacher: ____________________ Grade/Student ID#: ____________

Home #: ____________ Work #: ____________ Cell #: ____________

Emergency Contact: ______________________________

Home #: ____________ Work #: ____________ Cell #: ____________

This student has been instructed in the proper way to store and use her medication(s) and understands that these medications cannot be shared with any other person. I understand that my student will be responsible for taking her medication independently, as prescribed, while on the overnight trip. Parent initials________

PRINT Parent /Guardian First and Last Name ______________________________

Parent/Guardian Signature ______________________________

Student Signature:______________________________ Date:____________

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Medication Name: ______________________________ Dose: ____________

When to use: ______________________________

Where will medication be stored on trip? ______________________________

Additional instructions: ______________________________

Prescribing Physician's Name: ______________________________

Date: ____________ Office #: ____________ Fax #: ____________

Rev. 03/31/2016