

WEST CHESTER AREA SCHOOL DISTRICT

No. 121AG7

ADMINISTRATIVE GUIDELINE
APPROVED: August 1, 2015
REVISED:

121AG7 FIELD TRIP PARENT DELEGATION OF MEDICAL AUTHORITY (GRADES 6-12 ONLY)

(Please complete and return to the student's teacher)

Name of Field Trip: _____ Date of Trip: _____
Student Name: _____ Date of Birth: _____
Building: _____ Grade: _____ Homeroom: _____
Name of Parent/Guardian (please print): _____

I am the parent/guardian of the above named student. (Date of birth must be completed above).
My child is diagnosed with _____ and is under the
treatment of _____ M.D. who has prescribed _____.
My child is responsible for self-administering. My child is of sufficient competence and maturity
to understand and to implement this regimen as prescribed per the West Chester Area School
District's medication policy (121AG6).

I hereby delegate to the West Chester Area School District and its designated employees and
agents my authority as parent and legal guardian of my child to authorize the self-administration
of his treatment regimen during the school-sponsored trip as listed on the date above. I
understand and accept that a school nurse will not be present at any time during this activity and
the teacher in charge will be responsible for the medication before and after my child self-
administers it.

PARENT/GUARDIAN signature & phone number

Date