POMONA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES & PROGRAMS
FIELD TRIP MEDICATION DOCUMENTATION

_____	_____	_____	_____
Student Name	Birthdate	Grade	Teacher

Medication:_____Dosage:_____Time:_____

Special instructions or precautions: _____

Date and time of medication administration: _____ Signature: _____

Remember to follow the 5 R's in administering medication:
Right medication
Right student
Right time
Right dose
Right route

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE OR HEALTH ASSISTANT
UPON RETURN TO SCHOOL

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