

Field Trip Child Specific Training log

School: _____

Field Trip Location: _____ Date: _____ Hours: _____

Trainer name: _____ Signature: _____ Date: _____

Date	Student Name	Grade	Medication Name	Name of Staff Trained	Signature of staff trained accepting responsibility to administer medication on field trip	Additional Training needed?

St. Lucie Public Schools
Division of Student Services

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