

# ARLINGTON CENTRAL SCHOOL DISTRICT

144 Todd Hill Road  
LaGrangeville, NY 12540

## LICENSED HEALTH CARE PRESCRIBER'S MEDICATION ORDER Overnight School Trip

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

### **This section: FOR PRESCRIBER USE ONLY!**

The student named above understands the proper use of and may self administer the following medication:

Diagnosis #1: \_\_\_\_\_

Medication #1: \_\_\_\_\_

Dose: \_\_\_\_\_

Time/Frequency: \_\_\_\_\_

Duration of treatment: ☐ Current school year

☐ Other \_\_\_\_\_

Possible side effects: \_\_\_\_\_

For diabetic meds, inhalers, Benadryl or EpiPens:

- May carry medication on self: ☐ Yes ☐ No
- If for an allergic reaction, please indicate reason for prescription: ☐ Anaphylactic Reaction  
☐ Local reaction ☐ Generalized reaction

Diagnosis #2: \_\_\_\_\_

Medication #2: \_\_\_\_\_

Dose: \_\_\_\_\_

Time/Frequency: \_\_\_\_\_

Duration of treatment: ☐ Current school year

☐ Other \_\_\_\_\_

Possible side effects: \_\_\_\_\_

For diabetic meds, inhalers, Benadryl or EpiPens:

- May carry medication on self: ☐ Yes ☐ No
- If for an allergic reaction, please indicate reason for prescription: ☐ Anaphylactic Reaction  
☐ Local reaction ☐ Generalized reaction

Licensed Practitioner: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

### **PARENT AUTHORIZATION**

Please allow my child to take the medication prescribed by our licensed health care practitioner. He/she understands the purpose and appropriate method and frequency of use. I understand that the medication is to be delivered by a parent or guardian in a properly labeled original container from the pharmacy. All prescription medications must be clearly labeled by the pharmacy with the student's name, name of medication and medication instructions.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent must deliver this form with medications to Health Office  
Do Not Fax**