HEALTH CARE PRESCRIBER'S MEDICATION ORDER FOR OVERNIGHT SCHOOL TRIP

Arlington High School Health Office
1157 Route 55, LaGrangeville, NY 12540
Phone: 845-486-4860 Ext. 31313
Fax: 845-350-4182

Student Name: _____ D.O.B. _____

Instructions: 1. Part A is to be completed only by a physician or other licensed prescriber.
2. Part B is to be signed by the parent/guardian and submitted to the school by _____.

Part A: MEDICATION ORDER from HEALTH CARE PROVIDER

This student is able to self-administer the following medication(s) independently:

Diagnosis _____

_____

Medication _____

Strength _____

Dose _____

Time/Frequency _____

Duration of treatment: ☐Current school year

☐ Other _____

Possible side effects: _____

_____

Diagnosis _____

_____

Medication _____

Strength _____

Dose _____

Time/Frequency _____

Duration of treatment: ☐Current school year

☐ Other _____

Possible side effects: _____

_____

Signature _____ Date _____

Licensed Practitioner _____

Address _____

Telephone _____ Fax _____

Part B: PARENT SIGNATURE

Please allow the student named above to self administer the medication(s) prescribed above independently. I understand that the medication must be provided and maintained in a properly labeled original container. All prescription medications must be clearly labeled by the pharmacy with the student's name, name of medication and medication instructions.

Parent/Guardian Signature _____ Date _____

Student Signature _____ Date _____

Note to Parent/Student: Please travel with a quantity of medication sufficient to meet your medical needs for the trip and potential delays. Large, unnecessary quantities of medication in excess of this are discouraged.