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: _____