Medical Information for Overnight Trip

Student Name_____

D.O.B. _____

Instructions:

- Carefully review the **School Medication Policy for Overnight School Trip** below.
- Complete, sign and return to the school Health Office.
- This form **MUST** be submitted whether or not the student requires any prescription or non-prescription medications on this trip.

Read and Review:
School Medication Policy for Overnight School Trip: If a student requires any medication for this trip a written physician's order is required together with parent/guardian permission. (See the attached school form, Health Care Prescriber's Medication Order for Overnight School Trip.) This includes all prescription and non-prescription medications, i.e. Tylenol, Advil, motion sickness meds, etc. All medications required must be stored in a properly labeled original container. All prescription medications must be clearly labeled by the pharmacy with the student's name, name of the medication and the instructions.
Answer the question below:
Will this student require any prescription or non-prescription medication for this trip? **NO** ☐ **YES** ☐ **If "YES": A written medication order from your doctor must be submitted using the school form, Licensed Health Care Prescriber's Medication Order for Overnight School Trip.**

I have read and understand the School Medication Policy for this trip as indicated above.

Parent/Guardian Signature _____

Date _____

HEALTH CARE PRESCRIBER'S MEDICATION ORDER FOR OVERNIGHT SCHOOL TRIP

OUR LADY OF LOURDES HIGH SCHOOL
131 Boardman Road
Poughkeepsie, NY 12603
Phone: 845 - 463 - 0400 Fax: 845 - 463 – 0174

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.