

Miller Place School District
WASHINGTON TRIP 2015
October 28th – 30th

(Medication form and medicine due by October 21, 2015)

**PARENT AND PHYSICIAN'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION IN SCHOOL OR SCHOOL
SPONSERED TRIPS**

A. To be completed by the Parent or Guardian:

I request that my child _____ receive the medication as prescribed by my physician. **The medication is to be furnished by me in the properly labeled original container from the pharmacy** that the school nurse or other designated person will administer.

Signature (Parent/Guardian): _____ Date: _____

HOME PHONE #: _____ Student's Assigned Bus #: _____

Cell #: _____

B. To be completed by the Physician:

I request that my patient _____ receive the following medication:

Diagnosis	Medication	Prescribe dosage, frequency & route	Time to be taken during trip hours	Duration of Treatment

Other recommendations: _____

Name of Physician (please print) _____

Signature: _____ **Date:** _____

MUST HAVE STAMP TO BE VALID

