Miller Place School District
WASHINGTON TRIP 2017

October 25th – 27th

(Medication form and medicine due by October 18, 2017)

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