** MEDICATION REQUESTS**

NAME: _____ **GRADE**: _____

PHYSICIAN MEDICATION REQUEST SECTION-To be completed by the DOCTOR ONLY!

It is necessary for him/her to have the following medication during **the overnight trip &/or during the year**:

Any medication allergies? _____If yes, please list: _____

Medication #1_____ Medication #2_____

Diagnosis_____ Diagnosis_____

Dosage_____ Dosage_____

Time to Be Administered_____ Time to Be Administered_____

*Adverse reactions that may occur for #1*_____

*Adverse reactions that may occur for #2*_____

Medication #3_____ Medication #4_____

Diagnosis_____ Diagnosis_____

Dosage_____ Dosage _____

Time to Be Administered_____ Time to Be Administered_____

*Adverse reactions that may occur for #3*_____

*Adverse reactions that may occur for #4*_____

Medication will be administered during the **overnight trips & school year.**

Starting on: _____ and Terminated on: _____

_____ _____

SIGNATURE OF PHYSICIAN PHONE NUMBER DATE

OFFICE STAMP HERE

PARENT/GUARDIAN MEDICATION REQUEST SECTION-To be completed by the Parent/Guardian

I hereby give permission for my child to receive medication as prescribed above by my child's physician. I also give permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and treatment.

Date: _____ Parent/Guardian Signature: _____