SOMERSET BERKLEY REGIONAL HIGH SCHOOL
HEALTH SERVICES

Date: _____

Group / Organization: _____

REQUEST FOR ADMINISTRATION OF MEDICATION ON A FIELD TRIP:

I herby allow my (circle one) son/daughter, _____,
(student's name)

to (circle one) receive/take _____
(name of medication)

as prescribed by his/her doctor for the period from _____ to _____.
(date) (date)

Name of Prescribing Physician: _____

Medication will be supplied by a parent/guardian of the child and labeled with the original doctor's order and prescription from a pharmacy. This label should include the student's name, the name of the medication, the dosage, and frequency medication is to be taken.

Inhaler, EpiPen, or Birth Control Pills may be self-administered by the student and/or self-carried.

Name of Medication: _____

Dosage: _____

Duration of Treatment: _____

Diagnosis: _____

_____ _____
(Parent/Guardian's Name) **(Parent/Guardian's Signature)**