

Bellport Middle School Washington DC Class Trip Medication Permission Form

Student Name: _____

Address: _____

Parent Signature: _____ Date: _____

Over the Counter Medications:

The following standard Over-the-Counter Medications will be provided by Student Council. Medications will only be administered by the school nurse if the medication has been approved by your physician.

Drug Name	Dosage/Route	Schedule and Indications	Comments
Tylenol			
Ibuprofen			
Sudafed			
Cough Drops			
Robitussin			
Dramamine			
Benadryl			
Immodium			

Physician's Name: _____ Phone #: _____

Physician's Signature: _____ Date: _____

Physician's Stamp:



All prescription medications must be delivered by the parent/legal guardian and brought to the Middle School during the luggage check in. All Medications must be in the original container.

Drug Name	Dosage / Route	Schedule and Indications	Comments

Inhalers:

I request that (child's name) _____ be permitted to carry the inhaler on his/her person. He/she has been instructed in and understands the medication's purpose, frequency, and appropriate method of use.

Physician's Printed Name: _____ Phone #: _____

Physician's Signature: _____ Date: _____

Physician's Stamp:

Epi-Pens:

(Child's name) _____ has been instructed in and understands the medication's purpose, frequency, and appropriate method of use.

The student's chaperone will carry the Epi-Pen. ***Epi-Pens must be delivered by the parent/legal guardian and brought to the Middle School during the luggage check in. Medication must be in the original container.***

Allergy/Epi-Pen: _____

Physician's Printed Name: _____ Phone #: _____

Physician's Signature: _____ Date: _____

Physician's Stamp: