CONFIDENTIAL! -FIELD TRIP MEDICATION ORDER/CONSENT FORM
Danvers High School Band

PLEASE PRINT OR TYPE IN BLACK INK

Student's Name _____ **Date of Birth** ____/____/____

PRESCRIPTION MEDICATIONS

1. Name of medication:_____Dosage: _____Route:_____
Frequency: _____ Reason for Taking:_____
2. Name of medication:_____Dosage: _____Route:_____
Frequency: _____ Reason for Taking:_____
3. Name of medication:_____Dosage: _____Route:_____
Frequency: _____ Reason for Taking:_____
4. Name of medication:_____Dosage: _____Route:_____
Frequency: _____ Reason for Taking:_____

The student has permission to self administer the above prescription medications.
(provided the nurse determines it is safe and appropriate).

Physicians Comments:

_____ ____/____/_____ _____
Licensed Prescriber's Signature **Date** **Parent/Legal Guardian Signature**

NON-PRESCRIPTION MEDICATIONS STUDENT WILL CARRY

1. Name of medication:_____Dosage: _____Route:_____
Frequency: _____ Reason for Taking:_____
2. Name of medication:_____Dosage: _____Route:_____
Frequency: _____ Reason for Taking:_____
3. Name of medication:_____Dosage: _____Route:_____
Frequency: _____ Reason for Taking:_____
4. Name of medication:_____Dosage: _____Route:_____
Frequency: _____ Reason for Taking:_____

Physicians Comments:

The student has permission to self administer the above non-prescription medications.
(provided the nurse determines it is safe and appropriate).

_____ ____/____/_____ _____
Licensed Prescriber's Signature **Date** **Parent/Legal Guardian Signature**

NON-PRESCRIPTION MEDICATIONS THE NURSES WILL CARRY IN A LIMITED SUPPLY

Please intial next to all medications that you give consent for the nurses to administer as needed

_____ Tylenol (regular strength)_____ Hydrocortisone Ointment

The student has permission to receive from the nurses the above initialed non-prescription medications as needed.

_____ ____/____/_____ _____
Licensed Prescriber's Signature **Date** **Parent/Legal Guardian Signature**