Montgomery High School

AUTHORIZATION FOR MEDICATION TO BE TAKEN ON OVERNIGHT FIELD TRIP

I, **(Parent/Guardian printed Name)** _____ request that my child be assisted in taking the medication described below as authorized by myself and my physician. I understand that I must bring the medication to the school nurse, in the original container, labeled by the pharmacy or prescribing physician and must include the following: (Ask the pharmacist for an extra bottle with the label for each med)

- Name of student
- Name of prescribing physician
- Name of medication
- Instructions as to dosage (amount, time and method)
- Indication of special storage, if needed
- Pharmacy name and phone number, if applicable

Please only bring the required quantity of medication needed for the trip and 1-2 additional days' supply in case of an emergency. Also, please pick up your medication at the same time you pick up your child.

Student _____ID #_____ D-O-B_____

Medication	Dose	Route	Time Taken	Special Instructions

****I UNDERSTAND THAT ALL MEDICATION NOT PICKED UP WITHIN 14 DAYS OF THE DATE BELOW WILL BE DISCARDED****

_____ _____

Parent Signature Date

_____ _____

Emergency Contact Number Printed Name

Revised 5-30-2013