DHS Music Department Overnight Medication Form

Please indicate in the first section of this form, any over-the-counter medication(s) that your student will need or are allowed to have, on this trip. If the student requires prescription medication(s), their medical provider **MUST** fill out the second section of this form.

PLEASE NOTE: STUDENTS WILL NOT RECEIVE ANY OVER-THE-COUNTER MEDICATIONS UNLESS THIS PORTION OF FORM IS COMPLETED AND SIGNED BY A PARENT OR GUARDIAN. *Please cross (X) this section out if **N0** OTC meds are allowed to be administered.*

STUDENT NAME:____

Over-the-Counter Medications (OTC): Must Be completed by Parent or Guardian

Please **CIRCLE** which of the following medications you give permission for your child to receive, if needed, while on field trip:

Acetaminophen Ibuprofen Antacid Motion Sickness Other_________________________

Parent's Signature (for OTC Meds): ____ Date: ____________

MUST BE completed by Camp Health Provider (camp use only)

MEDICATION/DOSE	Date/Init.	Date/Init.	Date/Init.	Date/Init.	Date/Init.	Date/Init.	Date/Init.	Date/Init.	Date/Init.

PRESCRIPTION MEDICATIONS: **Requires** the original labeled container from Pharmacy brought on field trip.

*Please cross (X) this section out if **N0** Rx meds are allowed to be administered.*

MUST BE completed by Medical Provider
(Please fill-in first two columns)

MUST BE completed by Camp Health Provider
(camp use only)

MEDICATION/ DOSE/ROUTE	TIMING (PRN, BID, QID, ETC)	Date/Init.	Date/Init.	Date/Init.	Date/Init.	Date/Init.	Date/Init.

CIRCLE AS APPRORIATE:

Inhaler Self-Carried Inhaler kept with Adult Epi Pen Self-Carried Epi Pen kept with Adult

Provider Signature (for RX meds):____ Date: _____________

Parent's Signature (for RX meds): ____ Date: _____________