

**Bridgewater-Raritan Regional School District  
MEDICATION ORDER FORM FOR OVERNIGHT TRIP**

***REQUIRED if YES box is checked on FORM B or for over the counter medications other than Advil, Motrin (Ibuprofen)/Tylenol (Acetaminophen) or prescription medications other than those with orders in the Health Office***

Student Name:		Birth Date:	
School: Bridgewater-Raritan Middle School		Grade:	
Parent/Guardian Name:			
Home Address:			
Parent/Guardian Phone Number:	Home:	Work:	Cell:

**MEDICAL PROVIDER INFORMATION:**

Name of Physician:	Physician Stamp
Address:	
Phone Number:	

MEDICATION	DOSE	ROUTE OF ADMINISTRATION	TIMES GIVEN	CONDITION BEING TREATED

I request that the medication, named above, be given to my child. The medical provider explained to me the medication, its purpose and possible complications. I hereby acknowledge that the Bridgewater-Raritan Regional School District shall incur no liability as a result of any injury arising from the administration of this medication and hereby indemnify and hold harmless the Bridgewater-Raritan Regional Board of Education and its employees or agents from any claims arising out of the administration of this medication.

Parent/Guardian Signature:	Date:
Physician Signature:	Date:

*PLEASE NOTE: This completed form, along with the medication must be brought to the school nurse by the parent/guardian or adult student. The medication must be in the original container appropriately labeled by the pharmacy or physician. Rev 1/19/17*