OFFICE OF STUDENT HEALTH SERVICES
PATCHOGUE-MEDFORD SCHOOLS
181 Buffalo Avenue
Medford, NY 11763
Telephone (631) 687-6420

REQUEST FOR SELF-ADMINISTRATION OF MEDICATION ON FIELD TRIPS

Student's Name _____ Grade _____ Date _____

PHYSICIAN STATEMENT

Condition requiring this medicine: _____

Name of Medication: _____

Dosage: _____ Duration: _____

Time(s) of day to be taken: _____

Any side effects? Yes No If yes, what? _____

_____

I certify I have completed the above information.

Physician's signature: _____
Date: _____ Physician's telephone number _____

Affix Physician's stamp here:

I _____ request that _____
(parent signature) (student's name)
be permitted to carry the medication on their person on field trips, during the _____ school year, as we consider the student responsible. The student has been instructed in and understands the purpose and appropriate method and frequency or use.

Parent/Guardian Statement: I hereby agree not to hold the Patchogue-Medford School District liable for any matter relating to the supervision of the self-medication procedure; it being recognized by me that it is not the responsibility of the school district or administer or supervise the administration of medication to students and that such supervision or self-medication is undertaken by the school district as an accommodation to me and my child _____.
(student's name)

Name of pharmacy: _____ Telephone number: _____

Signature of Parent/Guardian _____ Date: _____