Eastern Camden County Regional High Schools
Medication Form - Overnight Class Trips

Dates: _____ Location: _____

To be completed by the PHYSICIAN:

_____ may take the following medication(s)
Student's Name
during the trip. Must include name of medication, dosage, how often and reason.

Prescription:

_____

_____

_____

_____

Over the Counter:

_____

_____

_____

_____

_____ _____
Physician signature Address

_____ _____
Physician's Name/Stamp

_____ _____
Date Phone Number

To be completed by the PARENT/GUARDIAN:

I request that the above medication, in the original container, be carried and administered by my child. **No medication is to be shared or given to another student or person for any reason.** I acknowledge that the school districts and its employees and agents shall incur no liability as a result of my child taking their medications or medication given to another student.

_____ _____
Parent/Guidance Signature Date