 **ADMINISTRATION OF MEDICATION AUTHORIZATION ON A FIELD TRIP**

Dear Parents/Guardians,

In order to provide the safest environment for our students while on this trip, MPH will be following the regulations and guidelines set forth by New York State Public Health Law.

Please note the following procedures for the administration of any medicines during this field trip:

1. The "Administration of Medication Authorization for Field Trips" **must** be completed and signed by a NYS prescriber and the parent/guardian.
2. All medicine must be in the original container and labeled with the following information:

a) Name of Student

b) Exact Dosage

c) Time to take medication and frequency or exact time interval

d) Reason for medication

**Medicine will be placed in a zip lock bag, labeled with the student's name, and this order form.**

1. There will be no "stock" bottles of medicine provided. Parents must provide their child's medicine.
2. A student will be allowed to "self -carry" medication if the prescriber and the parent both agree the student can be safe and independent with their medications. Otherwise, the chaperone will carry the medications and the student will administer them. Check the appropriate choice below.

Name of Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| Medication | Dose | Route | Frequency /Time | Indication |
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 We have read and understand the above information. We hereby request medication to be carried and administered by the student as directed by this authorization for the duration of the field trip.

 We have read and understand the above information. We hereby request medication to be carried by a chaperone and administered by the student as directed by this authorization for the duration of the field trip

Signature of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Manlius Pebble Hill School ● 5300 Jamesville Road ● Syracuse, NY 13214 ● 315.446.2452 ● mphschool.org**