CONFIDENTIAL

Long Reach High School
Music Department Annual Spring Trip
Medication Form

USE THIS FORM FOR ALL MEDICATIONS (prescription or over-the-counter)

Student Last Name: _____ First: _____

Date of Birth: ☐☐ ☐☐ ☐☐☐☐ Grade: ☐☐

Physician Name: _____

Address: _____

_____

City/State/ZIP: _____, MD ☐☐☐☐☐

Phone: ☐☐☐ ☐☐☐ ☐☐☐☐

Enter ALL medications whether prescription (Rx) or over-the-counter (OTC). Use key below for entries.

Medication	Rx or OTC	Dose	Frequency	Route	Indication(s) also "X" if As Needed
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Medication: note name and whether prescription (Rx) or over-the-counter (OTC).
Dose should be with units such as 500 mg or 30 ml rather than "Take 1"
Frequency should be listed as "every 8 hours" or "once in the morning". Do not use abbreviations such as "q8h" or "qAM".
Route: spell out, such as orally, topically, injection
FOR OTC MEDICATIONS "ACCORDING TO LABEL" is perfectly acceptable.
Indications: note for what symptoms the medication is to be given - headache, pain, stomach ache, mild allergic reaction, ADHD, low blood sugar, etc.

Physician Signature: _____ Date: ☐☐ ☐☐ ☐☐☐☐

Parent Signature: _____ Date: ☐☐ ☐☐ ☐☐☐☐

Emergency Phone: ☐☐☐ ☐☐☐ ☐☐☐☐

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