REQUEST FOR ADMINISTRATION OF MEDICATION

EVERY prescription or over-the-counter medication requires this form, except acetaminophen/ibuprofen.
NOTE that the nurse will not exceed recommended dosage on the label without physician's order.
Use duplicate forms as needed for additional doctors/medications.

Student Name _____ Grade _____

Birth Date _____ Age _____ Room # _____

***Physician signature is only required for prescription medications, including asthma inhalers.*

PHYSICIAN SECTION: the above-named student is in my care and should receive the medications listed on page 2 of this form, as described below.

Physician Signature _____ Date _____

Physician Name (Print) _____

PARENT/GUARDIAN SECTION: I request and give my permission to the GHHS Band Camp nurse and his/her designee to administer the medications identified on this form, under the terms listed below. My signature below specifically affirms the following:

- *I understand and accept that occasional circumstances and activities occurring during camp may prevent administration of the medication on the recommended schedule.*
- *I understand that medication not collected by me at the end of camp will be discarded on or after the first day of school.*
- *I will deliver the medication in the original, labeled container to the camp nurse during check-in.*
- *I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.*

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (Print) _____

CAMP NURSE SECTION: I hereby affirm that I received the drug(s) identified on this form during Band Camp check-in, in what appeared to be the original container.

Nurse Signature _____ Date _____

Nurse Name (Print) _____

MEDICATIONS LISTED ON NEXT PAGE

EVERY prescription or over-the-counter medication requires this form, except acetaminophen/ibuprofen.
NOTE that the nurse will not exceed recommended dosage on the label without physician's order.
Use duplicate forms as needed for additional doctors/medications.

Student Name _____ Grade _____

Medication:								
_____ Prescription _____ OTC		Time	Sun	Mon	Tue	Wed	Thu	Fri
Route:	Dosage:							
Times:	Qty Taken:							
Possible side effects:								
Specific instructions for admin or storage:								

Medication:								
_____ Prescription _____ OTC		Time	Sun	Mon	Tue	Wed	Thu	Fri
Route:	Dosage:							
Times:	Qty Taken:							
Possible side effects:								
Specific instructions for admin or storage:								