Authorization To Dispense Medication At Camp

If medication can be given at home or after camp hours, please do so. However, if medication must be given during camp hours, this form must be completed. Please write one medication per page.

Student's Name: _____

I request that Theatre with a Twist, through the camp director or RN assist in the administering of medication to my child, according to the instructions below.

I understand that:

• Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses.

• Parent/guardian must provide specific instructions, as well as the medication

and any related equipment to the camp director.

• It will be the responsibility of the parent/guardian to inform the camp of any changes.

New medication or new doses will not be given unless a new form is completed and a

newly labeled container is provided.

• All medication will be taken directly to the camp director by the parent.

• Unused medication will be disposed of unless picked up within one week after medication is discontinued.

*** By signing this form I am acknowledging that the first dose of this medication was given by a parent or guardian and student was observed to have no known side effects

****

Name of Medication: _____

Dose: _____ Route (by mouth, topical, etc): _____

Time(s) to be given: _____ Stop Medication on: _____

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the personnel, employees and officials of Theatre with a Twist to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_____

Parent/ Legal Guardian signature Date

Home Phone_____ Work Phone_____

Pager/Cell Phone _____

To be completed by School Health Clinic Personnel only:

Date received: _____ Name of Medication: _____

Doses: _____