SCHOOL

Address

School Health Services

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING:

SCHOOL BAND PROGRAM TRIP TO (Location)

(TO BE COMPLETED BY A PARENT/GUARDIAN)

Student Name ____

I request that my child be assisted in taking the medicine(s) described below during the __________ Program trip to (location) by authorized persons or be permitted to medicate self as also authorized by me and my physician under the supervision of the nurse. I relieve the School Board of Education and its employees of any liability, which may result from the administration of medication to my child or from self-administration when certified by the physician.

Date Parent/Guardian Signature Home Phone Cell Phone

PHYSICIAN AUTHORIZATION

Name of Medication____

Dose: ________________________________ Route: ______________________________________

Time: ________________________________ Duration of Use: _______________________________

Diagnosis (reason for medication) ____

Is child capable and instructed in self-administration?______________________________________

Potentially life threatening condition for self-administration:

Possible side effects: ____

Emergency Intervention Protocol: (Epipen, inhaler, insulin, glucagon, etc.)

____

Other Comments:____

Date: ________________ Physician's Signature____

Physician's Name ____

Address ____

Telephone# ____