Medication Authorization Form

Please fill out one form for each individual medication

Student's Name _____ Birth date _____

Medication _____ Dosage _____

Route _____ Time of day medication is to be given: _____

Special Instructions:

Purpose of medication: _____

Possible side effects:

_____

Name of Doctor or person with prescriptive authority

_____

_____

Phone Number Date

This medication is to be administered:

_____ by student

_____ by PRiSM Staff

Note: All medication brought must be in the **original** container which clearly states the child's name, the health care provider, the name of the medication, date, time, and dosage. This form must be filled out completely in order for the medication to be given. This applies to prescriptions as well as over-the counter meds.

I hereby give my permission for _____ to take the medication listed on this form while at Snowbound, as ordered by the health care provider. I understand that it is my responsibility to furnish this medication in the original container which clearly states the child's name, the health care provider, the name of the medication, date, time and dosage.

Signature of parent or guardian

_____

Phone # _____

Date _____

_____

PRiSM staff signature