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 High Altitude, 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