



**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 August 17, 2021.*
- *I will deliver the medication in the original, labeled container to the camp nurse during check-in on July 25, 2021.*
- *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 on Sunday, July 25, 2021 in what appeared to be the original container.

Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

Nurse Name (Print) \_\_\_\_\_

**MEDICATIONS LISTED ON NEXT PAGE**



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*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:								

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_____ Prescription      _____ OTC		Time	Sun	Mon	Tue	Wed	Thu	Fri
Route:	Dosage:							
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