



Summer Program Medication Authorization Form

Please complete this form to authorize the administration of prescription medications during the summer program. A separate form is required for each child. All medications must be provided in original containers with proper labels.

SECTION 1: Student & Parent Information

Student Full Name: _____ Date of Birth: _____

Allergies: [] No [] Yes (Specify) _____

Parent/Guardian Name: _____

Parent/Guardian Cell Number: _____

Emergency Contact Name (if different): _____

Emergency Contact Phone Number: _____

Does your child require prescription or emergency medication (e.g. EpiPen, inhaler, seizure) medication to be administered during the summer program?

Yes

No

If "Yes" is selected, please have the prescriber complete Section 2 below.

SECTION 2: Medication Details and Prescriber's Authorization

Medication Name(s): _____

Reason for Medication: _____

Dosage: _____

Time(s) to be Administered/When to use: _____

Special Instructions (e.g., take with food, refrigeration, etc.): _____

Prescriber's Name/Title _____

Phone Number: _____ Fax Number: _____

Prescriber's Signature: _____ Date: _____



SECTION 3: Parent/Guardian Authorization

I understand that there will not be a nurse on campus during summer programs. I hereby request that an authorized school personnel administer the above-ordered medication. All medications should be picked up at the end of the summer program.

Acknowledgment

- I authorize the summer program staff to administer the medication(s) listed above as directed.

- I understand medications must be provided in their original containers with the prescription label on them.

- I release the program and staff from liability related to medication administration as authorized on this form.

Parent/Guardian Signature: _____ **Date:** _____