Authorization to Administer Medication Form

Any child requiring medication during the school or camp day is required to provide an Authorization to Administer Medication form that has been filled out by the child's parent/guardian and the child's physician. This form needs to be turned in to the office before your child's first day of school or camp. ***No medication will be accepted without receipt of completed and appropriate medication forms. A separate from is required for each medication. We can only accept the Pinecrest School/Summer Pavilion Authorization to Administer Medication Form.*** *Medication should be brought in to the school office at the beginning of the week for camp or at the beginning of the school year for school by a parent/guardian and must be picked up at the end of the week for camp or the end of the school year for school by a parent/guardian. Children may not transport their own medication. All medication must be in the original container, with the child's name, the name of the medication, and the dose of the medication indicated on the prescription label. Expired medication will not be accepted. All medications are placed in a locked location in the school office and may be dispensed only by the Head of School, Camp Director, Administrative Assistant, or other authorized staff. Students may not self-administer any medication, including cough drops or syrup, nasal spray, aspirin, insect repellent, sunscreen, or lip balm. Non-prescription medicine will not be administered.*

(TO BE COMPLETED BY THE PARENT/GUARDIAN – please write clearly & neatly)

Medication authorization for: ____ *(child's name)*. I have read and understand the above statement on medicine administration. Pinecrest School/Summer Pavilion has my permission to administer the following medication:

Name of Medication: ____

Dosage: ____

Time(s) or interval between times to be given _____________________________________

Date of Prescription: Effective from ____________________ to _______________________

Special Instructions (if any): ____

This authorization is effective from __________________ *(start date)* to _______________________ *(end date)*. The maximum period of time for an authorization is one year.

______________________________________ ______________________________

Signature of Parent/Guardian Date

(TO BE COMPLED BY THE CHILD'S PHYSICIAN FOR PRESCRIPTION MEDICATION – please write clearly & neatly)

I certify that it is medically necessary that the medication(s) listed below to be administered to ______________________________ *(child name)* during school/camp hours for a duration that exceeds 10 school/camp days.

Reason for taking medication (diagnosis): ____

Name of Medication: ____

Dosage: ____

Time(s) or interval between times to be given _____________________________________

Date of Prescription: Effective from ____________________ to _______________________

If this medication is given on an "as needed" basis, what are the indications for administration (e.g. symptoms, complaints, et cetera) and the time at which it may be given again? Please be specific:

____

Special Instructions (if any): ____

This authorization is effective from __________________ *(start date)* to _______________________ *(end date)*. The maximum period of time for an authorization is one year.

____ (_______)______________________________

Physician's Name (please print) Telephone Number

____ ______________________________________

Physician's Signature Date