Authorization for Administration of Medication Form 516A

Student's Full Name: _____

Medication Administration Procedure:

When a student needs to take medication during an **overnight** EMID programming time, the following procedure will provide for the safe administration of any prescription or nonprescription (over-the-counter) medication. Please note that participants are not allowed to keep any medications, even over-the-counter medications, they might bring to programs. All medication must be checked-in with staff upon arrival and will be dispensed as directed.

All medications that are prescription require a written authorization from both the parent/guardian AND the physician or authorized prescriber with details before any medication can be administered at EMID. The prescription label on the bottle with the name of student and physician/authorized prescriber will be sufficient for written authorization.

Note: Medication is to be supplied in the original UNOPENED over the counter bottle or in the prescription bottle with a pharmacy label.

Medication	Dose	Time/Frequency	Reason
1.			
2.			
3.			
4.			

Please note: If your child has an Individualized Education Plan (IEP), 504 Plan, and/or Individualized Healthcare Plan (IHP) which permits your child to retain their medications, in their possession, a copy of the document must be attached.
Student may self-carry/administer:_____

Health & Wellness:

What health issues does your student have that will be important for the camp staff to know to ensure a healthy, happy experience for your student?

Parent/Guardian Authorization

1. I request medication to be given at EMID program as prescribed by a physician/licensed provider.
2. If you so choose, you can give program staff permission to dispense non-prescription medication. For example, acetaminophen, ibuprofen, benadryl, etc. for routine needs. Stall will keep a record of the time of administration and the dosage given.
3. I release EMID staff from liability in the event of any reaction that the results from the medication.
4. I give permission for the Site Coordinator to consult/communicate with the above named physician/licensed prescriber, regarding my students health condition, medication actions, and side effects in case of an emergency.
5. I acknowledge that providing accurate and thorough information is important to ensure staff has access to the information to support the needs of my child.

_____ _____ _____

Parent/Guardian Signature | Relationship to Student | Date