

winter retreat at the castle

authorization for prescription medication(s) form

note: if your child is on multiple medications, please fill out a separate form for each medication

student's name _____ (last) _____ (first) gender _____

address _____ birthdate _____

city _____ state _____ zip _____ grade _____

physician name _____ physician phone _____

please list any known health conditions or problems _____

please list any known allergies _____

(if student's allergies require an EpiPen Auto Injector, it must be provided by parent)

the following section is concerning a specific medication:

diagnosis for which medication is given _____

name of medication _____

form _____ dosage _____ does it need refrigerated? _____

if medication is to be given DAILY, at what time? _____

If medication is to be given "WHEN NEEDED", please describe _____

how soon can it be repeated? _____

is student authorized to self-medicate himself/herself? _____

list significant side effects _____

other information: _____

PLEASE NOTE THE FOLLOWING

1. there will be a nurse on duty the entire weekend to maintain and administer the medications.
2. medication must be in the original pharmacy bottle with a pharmacy label.
3. bring enough supply for the entire weekend.
4. this form must accompany medication whenever it is handed to the nurse.
5. we will return any extra medications to your child at the end of the weekend to bring home.
6. this form will only be seen by authorized persons and will be destroyed at the end of the retreat.

(please check one) ☐ I request that my child be assisted in taking the medicine described above by authorized persons.
OR
☐ I permit my child to self-medicate himself/herself as authorized by me.

parent/guardian signature _____ date _____

parent/guardian name _____ phone(h) _____ (c) _____

emergency contact name _____ emergency contact phone _____