APPENDIX B

MEDICATION AUTHORIZATION AND PERMISSION FORM

Location: _____

Part A to be completed by a licensed physician unless copy of prescription and original prescription bottle is provided containing the information requested in Part A.

I hereby request that my son/daughter be allowed to take the following medication(s) at the Location identified above and/or at a Location sponsored field trip, event or activity.

Last Name of Minor	First Name	Sex	Birth Date

Name of Medication: _____

A. Physician's Instructions. (Complete where applicable)

_____
Purpose of Medication or Diagnosis

Dosage Prescribed	Date/Time Schedule	Dose Form (tablet/liquid)

Please notify this office if patient misses medication ☐ Yes ☐ No

Medication may have adverse effects (explain) _____

Special instructions and/or comments: _____

Print Name of Licensed Physician	Signature of Licensed Physician	Date

_____
Physician Address and Phone Number

B. Permission for Administration of Medication and/or Testing at Location and/or at Location sponsored Field Trip/Event/Activity: I request that my son/daughter identified above, be permitted to carry and use emergency medication (inhaler, epi-pen, insulin, etc.) and/or test for levels of blood sugar at the Location identified above and/or at a Location sponsored field trip/event/activity as prescribed by the physician above. I acknowledge and understand that no health care professional or other trained adult may be available at the Location or at the field trip/event/activity to assist, monitor or supervise my son/daughter's self-administration of medication or testing unless arrangements have been made in advance. In the event that my son/daughter is unable to self-administer or self-test, I agree that Location staff/chaperones may assist my son/daughter to the extent possible under the circumstances, but neither they nor the Location shall be liable for any adverse consequences or injury. I hereby give the Location staff/chaperones permission to call paramedics to render treatment to my son/daughter should that be necessary and to release medical information to first responders for that purpose. For all other medications, my son/daughter and I will comply with the Location's policies and procedures and will provide the Location with any medication my son/daughter requires in its original prescription bottle.

Parent/Guardian Name: _____ Emergency phone number: _____

Parent/Guardian Signature: _____ Date: _____