Harrison High School Marching Band
Band Camp Medication Authorization Form

Medicine Must Be In Its Original Container

Please – **<u>One Form per Medication</u>**

Child's Name: _____

Medication Name: _____

Type: Prescription ☐ Non-Prescription ☐

Dosage Amount: _____

Frequency:

- ☐ Everyday
- ☐ Only given when needed
- ☐ Other _____
  _____

Time Given:

- ☐ Breakfast (approx. 8 am)
- ☐ Lunch (approx. 12 pm)
- ☐ Dinner (approx. 6 pm)
- ☐ Evening (approx. 9 pm)
- ☐ As Needed

Side Effects/Anticipated Reactions: _____

_____

Special Instructions (if applicable):

_____

_____

_____

_____

PARENT AUTHORIZATION

I authorize the Camp Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to delegate to unlicensed personnel the task of assisting my child in taking the above medication. I also authorize the Camp Nurse to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the Camp Coordinator, his/her designee, or the Camp nurse. It must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

_____ _____ _____ _____

Parent's Signature | Date | Telephone: | Cell Phone:

Parent's Name (printed) _____