

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student's Name: _____ Birthdate: _____

Expedition: _____ Date: _____



This Portion to be Completed by Health Care Provider/Dentist

<u>Name of Medication</u>	<u>Dosage</u>	<u>Method of Administration</u>	<u>Time of Day To Be Given</u>
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Diagnosis _____

If given PRN, specify the length of time between doses.
Indicate if student will self-carry inhaler/epipen on his/her person.

Anticipated action _____

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated. Medication orders are good for the current trip only. There exists a valid health reason which makes administration of the medication advisable while the student is on this expedition or during such time that the student is under the supervision of trip officials.

Medication may be administered by medically untrained personnel.

Health Care Provider/Dentist Signature

Date of Signature

Printed Name

Phone Number



This Portion of the Form Is To Be Completed By Parent/Guardian

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the trip officials to administer the above identified medication to the above identified student in accordance with the health provider's prescribed instructions, not to exceed the current trip dates.

Medication must be supplied to the school in the original container

Parent/Guardian's Signature

Date of Signature

Phone Number: Home/Work (indicate area code)