Medication Administration Authorization Form

Date ____

My child, ____, will be taking the following medication:

(Name of medication and dosage)____

Reason: ____

I hearby authorize The Laurel School/The Laurel Day Camp to administer the medication.

Parent/Guardian Signature ____

Please refer to the following policy as stated in the Family Handbook:
Medication will be administered in accordance with state licensing regulations and school/camp policy.

Medication prescribed for children shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, continued in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include directions for use.

Date	Dosage	Time	Signature of Staff Person

Date	Dosage	Time	Signature of Staff Person