

CRESTWOOD COUNTRY DAY SCHOOL

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PARENT AND PRESCRIBERS AUTHORIZATION FOR ADMINISTRATION OF MEDICATION DURING SUMMER PROGRAM 2008

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN – parent or guardian signature required at the bottom of part A.

I request that my child _____ receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the Crestwood nurse or a designated Crestwood staff member will administer the medication and neither the Nurse or Crestwood will be liable for any side effects and/or adverse reactions experienced by administering the medication as prescribed below.

FOR EPIPEN ONLY: I give permission for the Crestwood nurse or an epipen certified Crestwood staff member to administer an epipen to my child.

Signature (Parent or Guardian): _____

Address: _____

Telephone: Home: _____ Work: _____ Date: _____

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER – Prescriber's signature required at the bottom of part B.

I request that my patient, as listed below, receive the following medication:

Name of Child: _____ Date of Birth: _____

Diagnosis: _____

Name of medication: _____

Prescribed dosage, frequency and route of administration: _____

Time to be taken during summer program hours: _____

Duration of treatment: _____

Possible side effects and adverse reactions (if any): _____

Other recommendations: _____

Name of licensed prescriber and title (please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____