ADMINISTRATION OF MEDICATION DURING MAGIC ADVENTURES

MONTICELLO PUBLIC SCHOOLS HEALTH SERVICES

Student Name _____ DOB_____ School/Grade _____/____

Parents of pupils requesting that any prescription medication (or OTC medication beyond the recommended dosage) be administered during program hours by Magic Adventures staff are required to provide for the school:

1) The **Physician's order**,
2) A **Parental release**, and
3) Medication supplied in the **original container**.

PHYSICIAN AUTHORIZATION

Medication:_____Dosage:_____ Time:_____

Start Date:_____ Stop Date:_____ Route:_____

Diagnosis:_____Possible Side Effects:_____

Physician Printed Name:_____Clinic:_____

Physician Signature:_____Date:_____

PARENTAL REQUEST FOR ADMINISTRATION OF MEDICATION

I request this medication be given as prescribed and I give the Magic Adventures Staff authority to communicate with the ordering physician about this medication. I release Magic Adventures/school personnel from any liability in the administration of this medication at Magic Adventures. I understand that medication will be administered by the designated personnel as delegated by the Program Coordinator. Please check the appropriate spaces below:

1. Physician and I agree this student needs medication on field trips: Yes_____ No_____

Parent/Guardian Signature _____ Date_____ Phone _____