

2023-2024

STOCK OVER-THE-COUNTER MEDICATION



13500 Layhill Road, Silver Spring, MD 20906

301-576-2800 fax: 301-576-2805

barrie.org

Authorization Form for Age 6 and up

Part 1: Completed by Parent or Guardian

I hereby request and authorize Barrie School and/or Camp personnel to administer Over-The-Counter (OTC) medications as directed by the physician (Part 2 below). I agree to release, indemnify, and hold harmless Barrie School, Barrie Camp, and any of its officers, staff members, nurse delegates, or agents from lawsuit, claim, demand, or action against them for administering the following ordered medication(s) to this student, provided the Barrie School and Camp staff are following the physician's order as written in Part 2 below. Unless otherwise provided, stock medications provided in the health office will be used.

Student: _____ DOB: _____ Grade: _____

Allergies: _____

Parent or Guardian's Printed Name: _____

Parent or Guardian's Signature: _____ Date: _____

Part 2: Completed by Physician

The Montgomery County Department of Health and Human Services and Barrie discourage the administration of medication to students in school during the school or camp day. Any necessary medication that possibly can be administered before or after school or camp should be given outside of school or camp hours. Barrie personnel will, when it is absolutely necessary, administer medication to students during the day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined on the following pages of this form. Please do not use abbreviations. **I have read the above parent/guardian information and assume the responsibilities as required.**

The orders listed below are active for the following dates: (Check all that apply)

- Camp and Summer Programs 2022
- School Year 2022-2023

Please check the following:

- Tylenol (Acetaminophen)**
Dosage: _____ Frequency _____ Indications for use: _____
- Motrin(Ibuprofen)**
Dosage: _____ Frequency _____ Indications for use: _____
- Benadryl (Diphenhydramine HCL)** as indicated for allergy
Dosage: _____ Frequency _____ Indications for use: _____

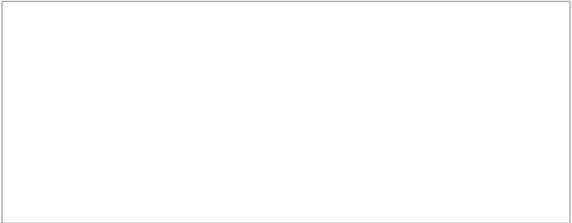
Physician's Name: _____

Address: _____

Phone: _____

Signature: _____

Date: _____



Physician's Stamp

Approved by School/Camp Nurse: _____

Date: _____