

Carroll County Outdoor School Prescribed Medication Form

This form is to be **completed and signed by the authorized** prescriber and signed by a parent/guardian for prescribed medications to be given at Outdoor School. This includes both prescription and over the counter medications, except those listed on the previous page. **All medications and orders on file at your child's school will be forwarded to Outdoor School for the week they will be attending.**

Student Name: _____ D.O.B.: _____ Allergies: _____

Medication: _____ Route: _____ Dosage: _____

Frequency: _____ Reason: _____

ODS Use Only	Time	Monday - ____	Tuesday - ____	Wednesday - ____	Thursday - ____	Friday - ____

Medication: _____ Route: _____ Dosage: _____

Frequency: _____ Reason: _____

ODS Use Only	Time	Monday - ____	Tuesday - ____	Wednesday - ____	Thursday - ____	Friday - ____

Medication: _____ Route: _____ Dosage: _____

Frequency: _____ Reason: _____

ODS Use Only	Time	Monday - ____	Tuesday - ____	Wednesday - ____	Thursday - ____	Friday - ____

Parent/Guardian Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Name: _____ Healthcare Provider Phone #: _____

Nurse Signature	Initials	Nurse Signature	Initials