School Year: 2025-2026

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:_____ Strength: _____Route:_____Dosage:_____

Frequency:_____Reason: _____Time of Day to be given:_____

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

Medication:_____Strength:_____Route:_____Dosage:_____

Frequency:_____Reason: _____Time of Day to be given:_____

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

Medication:_____Strength:_____Route:_____Dosage:_____

Frequency:_____Reason: _____Time of Day to be given:_____

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

Parent/Guardian Signature: _____ Date:_____

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Name:_____ Healthcare Provider Phone #: _____

Healthcare Provider Fax #: _____

_____ _____ _____ _____

_____ _____ _____ _____

Nurse Signature Initials Nurse Signature Initials