Student's Name: _____

# Authorization for Medication Supervision/Assistance

## Medications During Camp Hours

Students will not be allowed to carry medications while at School with the exception of emergency medicines such as EpiPens and diabetic medicines and supplies.

**For Daily Medication (Prescription)**

**This *Authorization for Medication Supervision/Assistance* form must be filled out and signed by the Student's Parent(s).**

- Medication must be in the original container with the prescription label intact. Please do not make changes on the label. The written order from the physician is the order that is followed.
- A new *Authorization for Medication Supervision/Assistance* form is required if the dose is changed.
- Students are not allowed to transport medication.
- Parents must pick up left over medication at the end of the camp or when a medication is discontinued. All medication not picked up by the end of camp is disposed of after the last day of school for students.

**Emergency Medication**

- An ***Asthma/Reactive Airway Disease Health Plan*** is required for students with asthma.
- An ***Allergic Reaction Health Plan*** form is required for students with severe allergic reactions requiring an Epipen/Twinject/Auvi-Q.
- A completed ***Diabetes Care Plan for Students who Receive Insulin by Injection*** or a ***Diabetes Care Plan for Students who Receive Insulin by Pump*** form is required for students with diabetes.
- If a student carries emergency medication, backup emergency medication is required to be left in the clinic.

| | |
|---|---|
| **Student Name** | |
| **Grade (2026-2027)** | |
| **Physician Name and Phone Number** | |
| **Medication Name** | |
| **Medication Strength** | |
| **Medication Instruction (Time of day, As needed, every __hours)** | |
| **This medication request is valid from (dates):** | _____ to _____ |
| **Special Instructions:** | |

I authorize the personnel of The Schenck School to assist my child in taking medication. I hereby release and waive, and further agree to indemnify, hold harmless or reimburse The Schenck School, the individual members, agents, employees and representative thereof, from and against any claim, which I, or other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses, damages or injuries arising out of, during or in connection with the administration/supervision/assistance of this medication.

I have read and agree to The Schenck School policy concerning medications during school hours.

**Parent/Guardian Signature and Date:** _____

**Please email this form to: eval@schenck.org.**

**282 Mt. Paran Road, NW, Atlanta, Georgia 30327 p.404-252-2591 f. 470-745-6298**