

SUMMER!KIDS@CARROLL

Medication Administration Authorization Form

I authorize school personnel to administer this medication to my child.

Parent Signature _____ Date _____

Student Name _____ DOB _____ Grade _____

Allergies _____

Reason for Medication _____ Date to begin _____ End date _____

Medication _____ Dose _____ Route _____

Time to be given _____ Side Effects _____

If prn for what symptoms _____ Frequency _____

Student may carry and self administer this medication? ___ NO ___ YES ___ Supervised ___ Unsupervised

Physician (print name) _____ Phone# _____

Signature _____ Date _____

MEDICATION ADMINISTRATION RECORD (Camp Use Only)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
June																																
July																																
Aug																																

Name/position _____ Initials _____ Codes : X= Weekend H= Holiday O=Omitted A= Absent N= None Available ED = Early Dismissal F= Field Trip
 _____ R = Refused D/C = Discontinued
