

NEW TRIER TOWNSHIP HIGH SCHOOL DISTRICT 203

Authorization to Administer Prescription and Non-Prescription Medication for Off Campus School Sponsored Activities

- Requires parent and physician signatures.
- Medication needs to be in a prescription-labeled container.

I authorize (*staff member*) _____ to oversee the administration of medication for (*name of student*) _____ for (*activity and dates*) _____.

Medication: _____

Dose: _____ Number of doses provided: _____

When to take: _____

Health condition for which medication is prescribed: _____

Possible side effects: _____

Check all that apply:

- Student may carry medications and self-administer.
- Take medication with food.
- Take medication on an empty stomach.
- Requires training for administration.

If training required, (name of qualified person) _____ will train staff member.

Other instructions: _____

Signatures:

Staff member volunteering to administer medication or oversee student allowed to self administer: _____

Parent/guardian: _____

Phone numbers to reach parent if there are questions or concerns: _____

Physician: _____ 3/16