Prescription Medication Administration Form

This form is to be completed and submitted for each trip with CSM along with below described medications.

Student's Name: ___________________________________ Birthdate: ___/___/___ Age: __ Sex: ___ Male ___ Female

As the parent or legal guardian of the above-named child, I give my permission to the enlisted Crestview Student Ministry to administer as prescribed by law the listed below medication to my child.

____ _________ (______) ______________ (______) _____________
Parents/Guardian Signature Date Daytime Phone # Evening Phone #

For Prescription Medications only...PLEASE follow these guidelines: In accordance with Texas Department of Health regulations: ALL Medication that is brought must be: (1) Placed in the care of a CSM Adult worker, (2) Prescribed for the student (not a sibling or parent), (3) In the original container with all labels intact, and (4) Correct current dosage clearly marked. Dosage of non-prescription medication may not exceed product recommendation without doctor's written orders. CSM requests that you do not send over-the-counter medications (i.e. Tylenol, Ibuprofen, Benadryl, etc.) unless consistently needed by student.

If necessary, make additional copies of this blank Medication Form in order to provide requested information for each medication. All Medication Release/Administration Forms and medication(s) to be administered should be given to CSM Adult Workers. The Forms will be reviewed to clear up any possible questions about medications or their administration. To make it easier the parent/or student should put their medications and forms in a zip-lock type plastic bag with the student's name written with a marker on the outside of the bag. Parents should emphasis to their student the responsibility of reporting for their medications while with CSM.

✂✂---------------------------Cut here and place forms in zip-lock type bags with medication✂✂-----------------------------------

Name of Medication:____
Purpose for medication use (e.g. allergies, asthma, antibiotic)____
Form of medication: ___ Tablet ___ Pill ___ Capsule ___Liquid ___ Inhalation ___ Other (specify)__________________
Dosage (amount to be given): __________________________________ How often or at what time:_________________
Remarks or special instructions: ____

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Purpose for medication use (e.g. allergies, asthma, antibiotic)____
Form of medication: ___ Tablet ___ Pill ___ Capsule ___Liquid ___ Inhalation ___ Other (specify)__________________
Dosage (amount to be given): __________________________________ How often or at what time:_________________
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Form of medication: ___ Tablet ___ Pill ___ Capsule ___Liquid ___ Inhalation ___ Other (specify)__________________
Dosage (amount to be given): __________________________________ How often or at what time:_________________
Remarks or special instructions: ____