**Student Daily & Prescription Medication Form 2022**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Under certain circumstances, as a service to you and for the welfare of your child, school personnel may agree to honor parent requests for the administration of necessary prescribed medication to students.

**Please complete** the chart below for each medication the student named above is currently taking. Include both prescription and non-prescription medication. Instructions must be the same as on the medication container.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Medication** | **Condition** | **Prescription Non-Prescription**  | **Breakfast** | **Lunch** | **Dinner** | **Bedtime** | **Special Instructions** |
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* ***Upon camp check in, check in all listed medications with the health officer. Pick up medications at camp check out.***

**Prescription Medication(s):** Must be in the original container, clearly labeled, and indicate the following information: Students name, prescription number, medication name, dosage, date issued, doctors name, pharmacy name, address, and phone number.

Over the counter Medication(s) that are taken on a daily basis: a dose schedule signed by the physician must be attached to this health form.

A nurse will be on site at all time while at Eagle Village. I understand all medications will be located in the Nurses Station at Eagle Village unless indicated otherwise indicated in special instructions. I understand that it is the responsibility of my child to report to the Nurses Station for his/her medication. I further understand that it is my responsibility to notify Mr. Arnold or MS Boren or any change or discontinuation of the medication.

I hereby authorize Lake Shore High School medical personnel or designee the right to administer medications as identified above on the following dates: July 24 – July 30, 2022

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Collector Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_