

West Orange High School Marching Mountaineers Band Camp Medication Authorization Form

Parents, please fill out the medication authorization form for your child(ren). This side is for prescription medication. The reverse side is for non-prescription medication. **This form is in addition to the medical form contained with the band camp paperwork.**

PRESCRIBED MEDICATION AUTHORIZATION FORM

1. AUTHORIZATION BY PHYSICIAN:

Name of Child _____ Date of Birth _____ / _____ / _____

Street Address _____ City _____ State _____

Condition for which drug is being administered during camp hours: _____

DRUG: Name of Drug, Dose and Method of Administration: _____

Times of Administration: _____, _____, _____

Medication shall be administered from _____ / _____ / _____ - _____ / _____ / _____

Relevant side effects to be observed, if any: _____

If there are side effects, plan for management: _____

Is this a controlled drug? _____

Allergies, reaction to, or negative interaction with food or drugs? If YES, list.

The authorized prescriber: (Physician)

Print Name _____ Phone # _____

Street Address _____ City _____ State _____

PHYSICIAN'S SIGNATURE _____ Date _____ / _____ / _____

2. AUTHORIZATION BY PARENT for the administration of the above medication:

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child be administered by the nurse or by camp personnel with current Medication Administration Training.

I understand that I must supply the Marching Band Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medications shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Print Name of Parent or Guardian _____ Relationship to child _____

Signature _____ Date _____ / _____ / _____

NON-PRESCRIPTION MEDICATION AUTHORIZATION FORM

Parent & Physician must initial each approved non-prescription medication on line provided & write full signature below.

Student Name _____ Age _____ Weight _____

Acetaminophen: tablets (i.e. Tylenol Regular Strength) 325 mg. ea.
elixir (80 mg. per 1/2 tsp) purpose: pain reliever/fever reducer
dosage: <110 lbs...1 tablets every 4-6 hours as needed; not to exceed 4 tablets in a 24 hour period
>110 lbs...2 tablets every 4-6 hours as needed; not to exceed 8 tablets in a 24 hour period or Elixir ...60-71 lbs: 2 1/2 tsp...; 72-95 lbs: 3 tsp...every 4 hours as needed; not to exceed 5 doses in 24 hour period
Parent's Initials _____ Physician's Initials _____

Ibuprofen tablets (i.e. Advil) 200 mg. ea.
oral suspension (i.e. Children's Advil) 100 mg. per tsp.
purpose: pain reliever/fever reducer
dosage: <110 lbs...1 tablet every 4-6 hrs.; not to exceed 4 tablets in 24 hr. pd.
>110 lbs...2 tablets every 4-6 hrs; not to exceed 4 tablets in 24 hr. pd.
for children 60-71 lbs: 2 1/2 tsp...72-95 lbs: 3tsp...every 6-8 hours as needed but no more than 4x a day
Parent's Initials _____ Physician's Initials _____

Pepto-Bismol chewable tablets or liquid
purpose: relief for upset stomach, indigestion, nausea, heartburn, diarrhea
dosage: <110 lbs.....1 tablet (or 1 tsp) every 1/2 to 1 hour as needed; max of 8 doses in 24 hr. pd.
>110 lbs...2 tablets (or 2 tsp) every 1/2 to 1 hour as needed; max of 8 doses in 24 hr. pd.
Parent's Initials _____ Physician's Initials _____

Mylanta liquid
purpose: antacid-anti-gas
dosage: >110 lbs...shake well, take 3 tsps. between meals; not to exceed 24 tsps. in 24 hr. pd.
Parent's Initials _____ Physician's Initials _____

Diphenhydramine HCL (i.e. Benadryl) tablets 25 mg. ea.; liquid 12.5 mg. per tsp.
purpose: relief from allergic reactions i.e. stuffy, runny nose, sneezing, itchy, watery eyes, itchy throat
dosage: <110 lbs...1 tsp. every 4-6 hrs.; do not take more than 6 doses in 24 hr. pd.
>110 lbs...2 tsp liquid or 1 tablet every 4-6 hrs.; do not exceed 6 tablets (6 doses) in 24 hr. pd.
Parent's Initials _____ Physician's Initials _____

Bacitracin ointment
purpose: prevention of infection in minor cuts, scrapes, burns
directions: apply small amount to affected area 1-3x daily
Parent's Initials _____ Physician's Initials _____

Caladryl lotion
purpose: relief from poison ivy
dosage: shake well; wash affected area; apply no more than 3-4x daily
Parent's Initials _____ Physician's Initials _____

Hydrocortisone cream 1%
purpose: relief of itching from minor skin irritations, inflammation & rashes
directions: apply to affected area no more than 3-4x daily
Parent's Initials _____ Physician's Initials _____

Parent & Physician full signature below:

Parent's Signature _____ Date _____

Physician's Signature & Title _____ Date _____