AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICATION AT SCHOOL-SPONSORED RETREAT OR OVERNIGHT EVENT

SMCPrep permits a student to carry and self-administer prescription medication while on an overnight event or retreat only with this written authorization from his/her parent and approval of the school nurse.

Name of Student _____ DOB_____Grade_____
Address_____
Name of medication, strength, dose & method administered
_____
Condition for which the medication is administered
_____
Side effects to be noted/reported
_____
Other recommendations
_____
Duration of administration: From _____ To _____ (dates of retreat/event)

PARENT/GUARDIAN AUTHORIZATION

(Please initial each statement)

____ I request that my child, named above, be permitted to carry and self-administer the above prescribed medication. I release SMCP and school personnel from liability in the event adverse reactions result from taking the medication.

____ I understand that the medication must be in the original pharmacy container, labeled with the name of the student, prescribing health care provider, name of medication, strength, dose and directions for use.

____ I understand that the container will have only the **exact amount** of medication needed while on the retreat/event.

____ I understand that the school nurse or event chaperone reserves the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. In this event, I will be contacted by the nurse or event chaperone as soon as possible.

Parent's/Guardian's Signature: _____

Date: _____

Student's Signature: _____

Date: _____