BARNSTORMERS THEATRE
Authorization for Medication Administration

Child's Name:_____ DOB:_____ Production/Program:_____

I am giving Barnstormers Production Personnel and/or Barnstormers Staff permission to administer medications to my child per the following:

Medication:_____ ❑ Non Prescription

Dose (how much):_____ ❑ Prescription Rx number:_____

Frequency (how often):_____

By: Mouth Ear Eye Nose Skin

Time:_____ Duration: Start date:_____End date: _____

Reason for Medication: _____

Special Instructions:

I understand I am responsible to provide this medication in its original (prescription or non-prescription) labeled container and maintain the supply as needed. I understand that I must deliver this medication to Barnstormers Theatre. I understand I am responsible to notify the organization of any changes in writing, and obtain a new prescription labeled container if the prescription is changed. Parents are required to pick up all unused medication by the last day of the production/program.. All medication left at the Barnstormers after this date _____ will be discarded.

Parent/Guardian Signature:_____Date: _____
(This authorization applies only to the medication listed above and for the duration of treatment or production/program.) This also authorizes an exchange of information, as necessary between production staff and employees of Barnstormers and/or my child's health provider.)

PHYSICIAN DIRECTION
(Required in writing or on pharmacy label for all prescription medications)

I have prescribed the above medication for the child whose name appears at the top of this form. Instructions in the box are accurate._____ Special instructions including adverse reactions and action required:

_____ _____
Physician's Name (please print/stamp) *Address/Phone*

_____
Physician's signature

Effective Date: _____

04/2023