SUMMER BAND HEALTH FORM
AUTHORIZATION FOR THE ADMINISTATION OF MEDICINE BY AUTHORIZED PERSONNEL

Child's Name_____ Date of Birth_____
Address:_____

Condition for which drug is being administered:_____
Name and Generic name of Drug_____Dose_____ Route____
Time of Administration_____ From_____ To_____
(date) (date)

Allergies ___No __ Yes Specify_____
Any additional information that the nurse should be aware of please specify here:

_____
Prescriber's Name/Title_____
Telephone #_____
Address_____
Prescriber's Signature_____ Date_____
Nurse's Signature_____ Date_____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by the authorized personnel (nurse) and I give permission for the exchange of information between the prescriber and the nurse necessary to ensure the safe administration of this medication. I understand that I must supply the nurse with the medication needed for the time my child is participating in the program (2 weeks).

Parent/Guardian Signature_____ Date_____
Parent's Home Phone #_____ Cell#_____Work#_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION APPROVAL

Self administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the nurse. In the case of inhalers for asthma and cartridge injectors for medically-diagnosed allergies, child may self administer medication with only the written authorization of an authorized prescriber and written authorization from a child's parent/guardian.

Prescriber's authorization for self administration ___ Yes ___ No
Signature_____ Date_____
Parent/Guardian authorization for self administration __ Yes __ No
Signature_____ Date_____
Nurse approval for self administration __ Yes __ No
Signature_____ Date_____

4/1/14