

Authorization for Medication Administration for Clearpool Trip

Name: _____

Grade: _____

School: BROOKLYN FRIENDS SCHOOL

Parent/Guardian Name: _____

Phone: _____

Cell: _____

Emergency numbers: _____

Medication and dosage: Is this a controlled substance? _____

Side effects: _____

Frequency and Time: _____

Date to Begin: _____ Date to End: _____

Physician's Name/ Signature: _____ Date _____ Seal: _____

Phone: _____

Medication and dosage: Is this a controlled substance? _____

Side effects: _____

Frequency and Time: _____

Date to Begin: _____ Date to End: _____

Physician's Name/ Signature: _____ Date _____ Seal: _____

Phone: _____

Medication and dosage: Is this a controlled substance? _____

Side effects: _____

Frequency and Time: _____

Date to Begin: _____ Date to End: _____

Physician's Name/ Signature: _____ Date _____ Seal: _____

Phone: _____

Brooklyn Friends School and Clearpool will act based on the information you give us. It is expected that it is accurate, complete and up-to-date. This information helps us better care for your child.

PHYSICIAN SIGNATURE is required above at each medication.

PARENT'S SIGNATURE _____ **Date** _____

*Please give your child's medication to Mary Ellen Ostrander RN.
Medication must be in the original container in a labeled zip lock bag with this authorization.*