



MEDICATION DISPENSING FORM:

To protect our students, Silton Swim School has a medication policy that requires both parent and physician authorization. Medication will be administered to students during camp hours only when such medication is needed by the student to remain in camp and administration is required during camp hours. All medication, both prescription and non-prescription must be kept in our office. Medication will be administered to students during camp hours only when such medication is required and accompanied by a doctor's order.

All medications must be brought to our office and stored in its original prescription labeled container in accordance with the manufacturer's instructions. Medication cannot be stored in your child's backpack or with your child's instructor.

Medication in baggies, envelopes, old pill bottles, or other family members' pill bottles is not acceptable and will not be administered. *In cases where this document is not available and administration of medication is necessary, our Health Director may obtain verbal orders/consent from a parent/guardian or physician. However, this document must be completed prior to future medication administration.*

REMINDER: ALL MEDICATIONS MUST BE KEPT IN OUR OFFICE AND STORED IN ITS ORIGINAL PRESCRIPTION LABELED CONTAINER. Medication will not be administered to any student without the below information.

TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER/PHYSICIANS ASSISTANT/DENTIST:

Student's Name: _____ Age: _____ DOB: ___/___/___

Name of Medication: _____

Dosage: _____ Frequency: _____ Time of Day: _____

Special Considerations: _____

Reason for medication: _____

Effective Dates: FROM: _____ / TO: _____

It is my understanding that the employees of Silton Swim School charged with the administration of this treatment/procedure during camp hours relay on directions contained in this document. I further certify that I am the health care provider who prescribed the treatment and that the student named above is under my supervision as a patient.

Physicians Signature: _____

Printed Name Physician: _____

Address: _____

Phone: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

As the parent/guardian of the above-named student, I hereby request that the treatment described above be administered to my child and release Silton Swim School and its employees from liability for any damages my child may suffer because of this request.

Parents Name: _____ Phone: _____

Signature of Parent/Guardian: _____ Date: _____