

Student Medication Form

Student Name: _____

Date of birth: ____/____/____

Student cell: _____

Name of Prescription	For treatment of	Dosage	When to Administer:				
			Bkfst	Lunch	Supper	Bedtime	If Needed

Please initial the following:

_____ I give the onsite healthcare professional permission to administer the medications listed above to my student. I covenant to hold harmless Green Acres Baptist Church, its sponsors and representatives, from any and all liabilities arising from the medical treatment for my student during this activity.

Over the Counter Medications:

_____ I give the onsite healthcare professional permission to administer the **over the counter** medication (OTC) to my student in the event he/she is ill or injured. I covenant to hold harmless Green Acres Baptist Church, its sponsors and representatives, from any and all liabilities arising from the medical treatment for my student during this activity.

Allergies: _____

Special instructions/other important info:

Parent/Guardian Signature: _____

Date: _____

Parent contact number: _____