2018/2019

OVER-THE-COUNTER MEDICATION

Authorization Form for Age 6 and up

Barrie

Serving age 18-months through Grade 12

13500 Layhill Road, Silver Spring, MD 20906

301-576-2800 fax: 301-576-2805 www.barrie.org

Part 1: Completed by Parent or Guardian

I hereby request and authorize Barrie personnel to administer Over-The-Counter (OTC) medications as directed by the physician (Part 2 below). I agree to release, indemnify, and hold harmless Barrie and any of its officers, staff members, nurse delegates, or agents from lawsuit, claim, demand, or action against them for administering the following ordered medication(s) to this student, provided the Barrie staff are following the physician's order as written in Part 2 below. Unless otherwise provided, stock medications provided in the health office will be used.

Student: _____ DOB: _____Grade:_____

Allergies: _____

Parent or Guardian's Printed Name: _____

Parent or Guardian's Signature: _____Date: _____

Part 2: Completed by Physician

The Montgomery County Department of Health and Human Services and Barrie discourage the administration of medication to students in school during the school or camp day. Any necessary medication that possibly can be administered before or after school or camp should be given outside of school or camp hours. Barrie personnel will, when it is absolutely necessary, administer medication to students during the day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined on the following pages of this form. Please do not use abbreviations. **I have read the above parent/guardian information and assume the responsibilities as required.**

The orders listed below are active for the following dates: (Check all that apply)

☐ Camp and Summer Programs 2018 ☐ School Year 2018-2019

Please check the following:

☐ Tylenol (Acetaminophen) as indicated for fever, cold symptoms, pain

☐ Motrin/Advil (Ibuprofen) as indicated for fever, cold symptoms, pain

☐ Benadryl (Diphenhydramine HCL) as indicated for allergy

Physician's Name: _____

Address: _____

_____

Phone: _____

Signature: _____

Date:_____

Physician's Stamp

Approved by School/Camp Nurse: _____ Date: _____