2021-2022

STOCK OVER-THE-COUNTER MEDICATION

13500 Layhill Road, Silver Spring, MD 20906
301-576-2800 fax: 301-576-2805
barrie.org

Authorization Form for Age 6 and up

Part 1: Completed by Parent or Guardian

I hereby request and authorize Barrie School and/or Camp 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 School, Barrie Camp, 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 School and Camp 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 2021 ☐ School Year 2021-2022

Please check the following:

☐ Tylenol (Acetaminophen)

Dosage: ____________________ Frequency____________________ Indications for use: _________________

☐ Motrin(Ibuprofen)

Dosage: ____________________ Frequency____________________ Indications for use: _________________

☐ Benadryl (Diphenhydramine HCL) as indicated for allergy

Dosage: ____________________ Frequency____________________ Indications for use: _________________

Physician's Name: ____

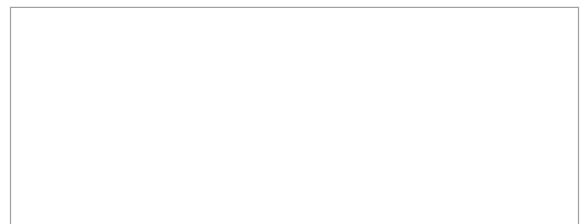
Address: ____

____

Phone: ____

Signature: ____

Date:____



Physician's Stamp

Approved by School/Camp Nurse: ____ Date:_______________