

Birth Date _____ Child's Name _____

Date attending GBOS _____ Teacher's Name _____

Prescription Medication Authorization

Sending Medications

In order for your child to receive prescription medication while attending the Great Basin Outdoor School, the following must be filled out by your child's physician. All medications along with this completed form must be turned in to your child's classroom teacher. Prescription medications will be stored in a secure area and given by the classroom teacher. Prescription medication must be in its original container with the pharmacy label attached and must be prescribed to the student to whom it will be administered. No prescription medications will be administered without a current physician's authorization AND signature.

Medication Information

| Medication | Dosage and times taken | Condition being treated | Possible side effects |
|------------|--|-------------------------|-----------------------|
| | <input type="checkbox"/> Required <input type="checkbox"/> As Needed | | |
| | <input type="checkbox"/> Required <input type="checkbox"/> As Needed | | |
| | <input type="checkbox"/> Required <input type="checkbox"/> As Needed | | |
| | <input type="checkbox"/> Required <input type="checkbox"/> As Needed | | |

Please note if these medications should not be taken with specific over-the-counter medications, or any other remarks:

Physician Authorization

Printed Physician's Name _____

Title _____ License No. _____ Phone _____

Signature of Physician

Date

Parent Authorization

I have reviewed and understand the above and acknowledge that the information provided is accurate. I request that my child, named above, be administered medication as directed by my child's Health Care Provider. My signature below also authorizes the designated staff person or classroom teacher to consult the above named Health Care Provider regarding my child's medical/medication needs. I understand that I must notify the teacher if the medication is changed or stopped.

Signature of Parent/Guardian

Date

Birth Date _____ Child's Name _____

Date attending GBOS _____ Teacher's Name _____

Over-the-Counter Medication Authorization

Sending Medication

In order for your child to receive *over-the-counter* (non-prescription) medications while at outdoor school, this form must be completed and signed. All medications along with this completed form must be turned in to your child's classroom teacher. Over-the-counter medications will be stored in a secure area and self-administered by the child, under the supervision of the classroom teacher. Over-the-counter medication must be in its original container.

Sunscreen, moisturizing lotion, lip balm and insect repellent do not require any special authorization and may be kept by the student during the week, but should not be shared with other students. No sprays should be sent due to health and allergy concerns for other students. If your child did not bring but requests any of these four medications during the week, the classroom teacher may provide them from GBOS stock if you initial the item below.

_____ sunscreen _____ moisturizing lotion _____ lip balm _____ insect repellent

GBOS does not stock and cannot provide any medications not indicated on this form. If you wish your child to have access to tylenol or ibuprofen, you must enter the information below and provide the medication.

GBOS and the classroom teacher are relieved of any responsibility for the benefits or consequences of the medication that is parent-prescribed and acknowledge that the school bears no responsibility for ensuring that the medication is taken.

Medication Information

| Medication | Dosage and times taken | Condition being treated | Possible side effects |
|------------|------------------------|-------------------------|-----------------------|
| | | | |
| | | | |
| | | | |
| | | | |

Parent Authorization

I have reviewed and understand the above and acknowledge that the information provided is accurate.

Signature of Parent/Guardian

Date