San Mateo Outdoor Education:
Medication Form

********** ATTENTION **********

Any medication brought to camp must be in its original prescription or manufacturer's packaging (NO loose pills) and must NOT be EXPIRED.

TO BE COMPLETED BY PARENT:

A **doctor's signature** is required for **all prescription** and **non-prescription** medication to be administered to your child. Please refer to the list of non-prescription medication available at Outdoor Education on the medical information and permission form before sending non-prescription medication from home.

Print name of student _____ Sex _____ Birth date _____ School _____

I request and authorize my child (named above) to be assisted by a designated person in taking their medication (described below) at the Outdoor Education Program, in compliance with the program's policies and procedures.

Signature of custodial parent or guardian _____ Date signed (month, day, year) _____ Phone Number _____

TO BE COMPLETED BY PHYSICIAN:

PHYSICIAN'S INSTRUCTIONS FOR ACUTE OR CHRONIC PROBLEM

If the child is under your care for an acute or chronic problem including food allergies or dietary restrictions, please give instructions in this space for care of the child.

_____

_____

_____

	1. Name of medication	2. Name of medication	3. Name of medication
Purpose of medication:			
Dosage prescribed:			
Time schedule:			
Dose form: (liquid, tablet, etc.)			
Date of prescription:			
Length of time medication is necessary:			

	4. Name of medication	5. Name of medication	6. Name of medication
Purpose of medication:			
Dosage prescribed:			
Time schedule:			
Dose form: (liquid, tablet, etc.)			
Date of prescription: Length of time medication is necessary:			

Precautions, special instructions, possible adverse effects, or comments: _____

_____

The above-named child, for whom the above medication is prescribed, is under my care.

Print Name of Physician _____ CA License Number _____

Address (street number, street name, suite or room number, city, and zip code) _____ Telephone number _____

Signature of physician _____ Date signed (mo./day/yr.) _____