Timberlane Music Association Washington, D.C. / Philadelphia, PA Trip April 24 – April 28, 2019

Physician's Request for Administration of Medicine
ONE PER MEDICATION

Student's Name_____ Date of Birth _____ Grade _____

Address _____Town _____ Zip _____ Student Cell Phone_____

Parent's Cell Phone: _____

Physician's Orders:

Diagnosis:_____

Medication: _____

Dosage: _____ Time(s) to be given: _____

Side Effects (if any for this patient): _____

_____

Restrictions on Physical Activity (if any) _____

_____

Physician's Name (printed) _____

Physician's Signature: _____ Date: _____

Parental or Guardian's Permission

I request the Trip Medical Staff Member to assist my child, _____ in taking any **prescribed medications** indicated for said child or approved "**over the counter"** medications deemed appropriate.

Prescription # _____ Pharmacy: _____ Phone#:_____

by Dr. _____ Dr. Phone #: _____

For the period from _____ to _____.

The medication listed above will be delivered to the Medical Assistants in original container with the student's name, physician's name, date of original prescription, name and strength of the medication and dispensing directions.

I, the parent or guardian, agrees by signing this request and 'Hold Harmless' statement that I shall not hold liable any member of the Timberlane Music Association Staff who is directed to assist my child in taking of these prescribed or Over the Counter Medicines.

Parent or Guardian Signature: _____

Printed Name: _____ Date: _____