

The Outdoor Academy of the Southern Appalachians
PRESCRIPTION & NON-PRESCRIPTION MEDICATION,
VITAMIN & SUPPLEMENT ADMINISTRATION

To be completed by the Parent

Name of Child: _____

Physician's Name: _____ **Physician's Phone:** _____

I. PRESCRIPTION MEDICATION(S):

Medication 1. _____ Dosage _____ Time to Take _____

Medication 2. _____ Dosage _____ Time to Take _____

Medication 3. _____ Dosage _____ Time to Take _____

Medication 4. _____ Dosage _____ Time to Take _____

No injection will be given except in extreme emergency, such as allergy to wasp or bee sting.

Significant Information (include side effects, toxic reactions, omission reactions) _____

Contraindications for Administration _____

II. NON-PRESCRIPTION MEDICATION(S), VITAMIN(S) & SUPPLEMENT(S):

Vitamin/Supplement 1. _____ Dosage _____ Time to Take _____

Vitamin/Supplement 2. _____ Dosage _____ Time to Take _____

Vitamin/Supplement 3. _____ Dosage _____ Time to Take _____

Vitamin/Supplement 4. _____ Dosage _____ Time to Take _____

Parent's Permission: I hereby give my permission for my child (named above) to receive the medication(s) and vitamins/supplements listed on this form while enrolled at The Outdoor Academy. A licensed physician has prescribed the above listed medications in Section I. The Outdoor Academy staff will administer the prescribed dosages at the prescribed times. As a parent, I am directing the administering of the vitamins/supplements listed in Section II above to my child at the requested times. I hereby release Eagle's Nest Foundation and The Outdoor Academy staff from any and all liability that may result from my child taking the prescribed medication(s) and/or the listed vitamins/supplements.

Signature of Parent or Guardian

Date

Printed Name