24/7 DANCE STUDIO MEDICATION AUTHORIZATION FORM

For the dance year 2017/2018

Start Date ___/___/___ to Stop Date ___/___/___

This medication form must be completed fully in order for staff to administer required medication. A new medication administration form must be completed at the beginning of each school year, for each medication and each time there is a change in dosage, or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or provider.
- Over-the-counter medication must be in the **original unopened container** with the label intact.
- Students are prohibited from transporting medications

NAME OF STUDENT _____ **DOB** ___/___/___

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____

Additional Instructions: _____

Specific Instructions for Inhalers (Please Check)

Symptoms for inhaler administration: Coughing ___ Audible Wheezing ___

Complaint of tightness in chest ___ Complaint of shortness of breath ___ Other_____

Specific Instructions for Epi-Pens

*Symptoms for Epi-Pen administration:*_____

_____

IMPORTANT INFORMATION FOR PARENTS/GUARDIANS

1. Please give your child needed medication at home if at all possible.
2. It is recommended that the first full day's (24 hours) dose of any new medication be given at home. If unsure, follow the recommendation of the health care prescriber about attending school during the first 24 hours.
3. If it is **ABSOLUTELY NECESSARY** for the student to take prescription, over-the counter or alternative medication at the dance school, this *School Medication* form must be completed for **each** medication and submitted to the front desk prior to medication being given at the studio.
4. Medications will be administered by the front desk staff who has been CPR and First Aid certified.
5. All medications must be labeled with the name of the medication, name of the student, name of the health care prescriber, date, and directions (e.g., specific time and dose) for administration.

PARENT/GUARDIAN AUTHORIZATION	
I give designated staff permission to administer the medication as prescribed above. I certify that I have legal authority to consent to the administration of medication at the dance studio. I understand that at the end of the dance year that the medication must be picked up by an adult by May 28 or it will be destroyed.	
Parent/Guardian Signature:	Date:
Home Phone:	Cell Phone: