HEALTH CARE PROVIDER INSTRUCTIONS FOR GIVING MEDICATION AT MZ KIDS EVENT

Student name: ________________________________Date of Birth__________Grade:___________

Allergies:____

Medication Name:_____________________________________Route:_______________________

Reason for Administration____

Exact Dose to be Given (**Must specify in mg/ml or # of puffs**):______________________________

Time/Frequency of Administration:__________________If prn, frequency:____________________

If prn, for what symptoms:____

Duration of Administration: Duration of VBS Dates:_____________________________________

Relevant Side Effects: None Expected______Specify______________________________________

Any additional instructions or follow-up:____

Health Care Provider Signature:_______________________________________Date_____________

Health Care Provider Name Printed:____

Phone:____

PARENTAL/LEGAL GUARDIAN AUTHORIZATION

- I request designated health care provider to administer the medication as described above
- I certify that I have legal authority to consent to medical treatment for the student named above
- I authorize the nurse to communicate with me or alternate person listed below as needed

Parent/Person Responsible:____

Date:_____________________Phone: Primary________________Secondary__________________

Parent/Legal Guardian Name:____

Phone #1_________________________________#2______________________________________