# PRESCRIPTION MEDICATION ADMINISTRATION

**Student Name ________________________________________________**

**Date of Birth___________________________ Band ________________**

**Health Care Provider ____________________Phone _______________**

**Emergency Contact Numbers for Parents:**

**Name:_________________________________Cell Phone: ____________**

**Name:_________________________________Cell Phone:_____________**

**Home Phone ___________________________**

| Name of Medication | Dose | Approx. Time Administered | Reason for Medication |
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**Medication Allergies___________________________________________________**

**I give permission for HHS BPA chaperones to administer the above listed medications to my child.**

**Signature____________________________________Date _________________**