BAND & GUARD MEDICATION RELEASE AUTHORIZATION FORM

My Student, ________________________________is currently taking the following **prescription medications**, in the doses indicated for the noted reason.

Medication: ____
Reason for Medication: ____
Dosage: ____
Time(s) to be dispensed: ____

Medication: ____
Reason for Medication: ____
Dosage: ____
Time(s) to be dispensed: ____

Medication: ____
Reason for Medication: ____
Dosage: ____
Time(s) to be dispensed: ____

Medication: ____
Reason for Medication: ____
Dosage: ____
Time(s) to be dispensed: ____

****

I hereby authorize the Head Chaperone of James Logan Band & Color Guard to give my student the following over-the-counter medications for headaches, colds and general aches and pains. I understand that I will be notified of any medications given to my student.

Listed below are any over-the-counter medications you are allowed to give my student in my absence. (Please include medications such as Tylenol, Advil, Motrin, Aspirin, etc.; Cough Drops, Sudafed, Claritin, etc.)

________________________________Dosage: ________________________________
________________________________Dosage: ________________________________
________________________________Dosage: ________________________________
________________________________Dosage: ________________________________

_________________________________ __________________
Parent's Signature Date

****

I DO NOT want any over-the-counter medications dispensed to my student at any time.

________________________________ __________________
Parent's Signature Date