Battle Creek Public Schools
Outdoor Education Center
10160 South M-37 HWY
Dowling, MI 49050
269-721-8161 FAX: 269-721-1071

MEDICATION PERMISSION FORM
For ANY medication (Including: Prescription drugs, Over-the-counter drugs, herbal supplements, vitamins, cough drops)

Student Name: _____ Grade: _____

Date of Birth: _____ School: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I request that (My Child) _____ receive the listed medications at camp. I understand that the medication will be administered exactly as per the directions of the prescribing physician.

Parent/Guardian Signature: _____Date:_____

Address: _____Telephone:_____

Prescribing Physician: _____

Address: _____Telephone_____

TO BE COMPLETED BY PHYSICIAN:

Please include exact drug name and mg/ml/mcg (Dosage).
Typical camp med times are meal times- (B, L, D), 4:00pm and Bedtime.

Medication:

(1) Name of medication: _____
Dosage: _____ When given:_____
Reason for Medication:_____
Special instructions: _____

(2) Name of medication: _____
Dosage: _____ When given:_____
Reason for Medication:_____
Special instructions: _____

(3) Name of Medication:_____
Dosage:_____When given:_____
Reason for Medication:_____
Special instructions: _____

(4) Name of Medication:_____
Dosage:_____When given:_____
Reason for Medication:_____
Special instructions: _____

(5) Name of Medication:_____
Dosage:_____When given:_____
Reason for Medication:_____
Special instructions: _____

(6) Name of Medication:_____
Dosage:_____When given:_____
Reason for Medication:_____
Special instructions: _____

ORDERS MAY BE FAXED DIRECTLY TO OUR OFFICE AT 269-721-1071

If more space is needed, fill out and sign a second form. Please put an X through unused spaces.

□ **Physician's Signature:** _____