

**WEBSTER CENTRAL SCHOOL DISTRICT
 PERMISSION FOR ADMINISTRATION OF MEDICATION
 WEBSTER HIGH SCHOOL MARCHING BAND**

If your child needs ANY medication during MARCHING BAND EVENTS, either prescription or over the-counter medications, you must comply with the following or medication cannot be administered:

1. Have your child's licensed Medical Care Provider complete the **Physician Statement** section of this form entirely;
2. Complete the **Parent Statement** section of this form entirely;
3. Parent must bring the medication to Marching Band in the **original labeled container** (unless it is an OTC medication that the medics carry).

Student's Name: _____

DOB: _____

PHYSICIAN STATEMENT

Marching Band Season: 2018

Medication:				
Dosage (BE SPECIFIC):				
Administration Time:				
Duration of Order:				
Possible side effects:				
Reason for medicine:				
Has patient taken before?	Yes	No	Yes	No
			Yes	No

Based on the definitions below, I assess this student to be:

___ **Not Self -directed** (must be reminded & supervised in storage & administration of medication).

___ **Supervised (Self-directed)** (can recognize medication, knows dose & time of delivery, can refuse to take the wrong medication from an authority figure).

___ **Independent Use (Able to carry and self-administer)** (as in self-directed, **plus** understands need to keep medicine away from other students and safely stored, can recognize when medication supply needs replenishing, can keep track of dosing and timing of medication, know to seek assistance if medication is not working).

___ **May use for all Marching Band Events including any overnight trips.**

Physician's signature

Office Stamp

Date

PARENT STATEMENT

By completing and signing this form, I give permission for my child as named above, to take this medication as prescribed above. **I understand the determination of whether my child is self-directed or not self-directed is the ultimate responsibility of the Marching Band Director during marching band events.** I further understand that any assessment may change based on a student's demonstration of responsibility. I assume responsibility for and assess my child to be:

___ **Not Self -directed** (must be reminded & supervised in storage & administration of medication).

___ **Supervised (Self-directed)** (can recognize medication, knows dose & time of delivery, can refuse to take the wrong medication from an authority figure).

___ **Independent Use (Able to carry and self-administer)** (as in self-directed, **plus** understands need to keep medicine away from other students and safely stored, can recognize when medication supply needs replenishing, can keep track of dosing and timing of medication, know to seek assistance if medication is not working).

STUDENTS MAY NOT CARRY CONTROLLED MEDICATION

Parent signature

Daytime phone #

Date