

# Egremont School

19850 Devonshire St. Chatsworth, CA 91311 | +1 (818) 363 - 7803

## School Medication Permission Agreement Summer Camp 2026

Student's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Emergency Phone Number \_\_\_\_\_

**PARENT/GUARDIAN:** We at Egremont School realize it may be important for a student's well being that medicine be taken at school. It is also important that such medicines be approved and that administration of medicine follows school policies and guidelines based upon a physician's written authorization. This form is required before the school administers any medications. A separate form is required for **each medication** the student may be taking. Please include authorization and instructions from the student's physician or an authorized and qualified medical advisor.

### MEDICATION INFORMATION

Name of Medication \_\_\_\_\_

Condition Treated by this Medication \_\_\_\_\_

Dosage \_\_\_\_\_ Time(s) of Use \_\_\_\_\_

Duration Period Student Will Be Taking This Medication \_\_\_\_\_

Is Medication Necessary For Child to Remain in School? \_\_\_\_\_ Yes \_\_\_\_\_ No

Will Child Experience any Side Effects \_\_\_\_\_ Yes \_\_\_\_\_ No Possible Side Effects \_\_\_\_\_

Has Student Been Informed of Parent and Physician Instructions for Use and Storage of This Medicine? \_\_\_\_\_ Yes \_\_\_\_\_ No

Special Storage Instruction Request \_\_\_\_\_

### REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER

Parents are aware of the school's policies and procedures related to medication by school personnel? \_\_\_\_\_ Yes \_\_\_\_\_ No

Describe all administration conditions and procedures that those giving the medication should be aware of:

\_\_\_\_\_  
\_\_\_\_\_

### AUTHORIZATION SIGNATURES

**PARENT/GUARDIAN:** Your signature indicates the accuracy of the above information and your acknowledgement of school policies and guidelines for the administration of medication. **(No Cough Drops Will Be Given to Any Student)**

Please Print Parent/Guardian Name(s) \_\_\_\_\_

I, (we) hereby grant permission for Egremont School and/or its personnel to administer the above medication according to doctor's written orders and school policy.

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_