City of Hillsboro Parks and Recreation
Medication Authorization Form

Student: _____ Birthdate: _____ Program Location: _____ Grade: _____

PLEASE FILL OUT FOR ALL MEDICATIONS

Name of medication _____ Prescription number (unless OTC*) _____

Mg per tablet or teaspoon _____ Dosage to be given _____

Physician's name _____ Physician's phone number _____

Hours between doses _____ Amount in container _____

Given at home in the morning? _____ When _____

Time(s) to be given at program _____ Discontinue date _____

Reason for medication to be given at program _____

Special instructions _____ Expiration Date _____

*Over the counter medication

I hereby request and authorize program staff to give this medication in accordance with the instructions provided. I understand that the City of Hillsboro Parks and Recreation staff will not be held liable for dosage of my child with medication in accordance with the above instructions. I authorize the City of Hillsboro Parks and Recreation to release this information to appropriate staff members. **I also authorize the release and exchange of information with the physician regarding this medication.**

Date: _____ Parent Signature: _____

Home Phone: _____ Work Phone: _____

CHANGE IN DIRECTIONS REGARDING THIS MEDICATION:

Date: _____ Direction Change: _____ Parent Signature: _____

Date: _____ Direction Change: _____ Parent Signature: _____

Date: _____ Direction Change: _____ Parent Signature: _____

Date: _____ Direction Change: _____ Parent Signature: _____

Staff signature(s):

_____ _____

_____ _____

_____ _____