Westfield STATE UNIVERSITY

MEDICATION FORM

Westfield State University: H.E.L.P. Program
This form must be completed by student's parent or legal guardian.

Student name:_____ Age:_____ Birth Date:____/____/_____ Gender:_____

PRESCRIPTION MEDICATIONS

List **all prescription medications** you plan to send with your child and the reasons s/he takes them

Medication _____ Dosage _____ Time Given _____ Reason _____

Medication _____ Dosage _____ Time Given _____ Reason _____

Medication _____ Dosage _____ Time Given _____ Reason _____

Medication _____ Dosage _____ Time Given _____ Reason _____

- By signing the bottom, parents acknowledge that students are responsible for administering their own medications, unless otherwise noted below. Arrangements must be made with Westfield State University prior to the student attending the program.
- Your child's medication MUST be in the correct pharmacy prescription bottle with administration directions on the pharmacy label. Please note: "Administer according to directions" is not acceptable. If your child's prescription medication is not in its original container and labeled properly, it will not be administered.
- Prescription Medication LABEL must include: Student's name, Strength of the medication, dosage given, how often it is to be given, and expiration date of medication.

OVER THE COUNTER (OTC) MEDICINES

A parent or legal guardian MUST provide Westfield State with a list of OTC medications **that the student takes regularly**. Please list the medications you plan to send for your child and the reason(s) your child should take them. It must be in the original manufacturer's container with the student's name written on the container. OTC medications will be administered following manufacturer's guidelines. Attach additional sheets if necessary.

OTC Medication _____ Reason for giving _____

OTC Medication _____ Reason for giving _____

OTC Medication _____ Reason for giving _____

OTC Medication _____ Reason for giving _____

I hereby give permission for Westfield State University staff to administer the following medications as necessary, per manufacturer's dosage instructions:

_____ Advil/Ibuprofin

_____ Calamine Lotion

_____ Aloe Vera Gel

_____ Tums/Maalox

_____ Benadryl

_____ Tylenol

Specific precautions, possible side effects/adverse reactions to any of the medications listed above or any medications you request the Westfield State University to administer to your child:

_____

_____

_____

_____

FOOD RESTRICTIONS

_____

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_____

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The directions on this form regarding the administration of my child's medication are accurate. I give authorization for the Health Services Staff at Westfield State University to administer the medication listed on this form to my child, if necessary. I also authorize Health Services to talk with my child's physician or pharmacist should a question arise about the medicine.

Parent/Guardian (print)_____

Parent/Guardian (signature)_____

Date:_____