



## MEDICATION FORM

Westfield State University: Westfield CSI 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/Ibuprofen

\_\_\_\_\_ Tums/Maalox

\_\_\_\_\_ Calamine Lotion

\_\_\_\_\_ Benadryl

\_\_\_\_\_ Aloe Vera Gel

\_\_\_\_\_ 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

---

---

---

---

\*\*\*\*\*

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:\_\_\_\_\_