



Permit to Administer/Dispense Prescription Medication

Prescription medications can be provided to the certified athletic trainer by a parent or guardian of a student athlete so that a specific condition may be treated during an athletic event or practice session. **These medications are to be provided by the athlete's parent or guardian.** These medications will be held until such time that the athlete needs them. Please fill out the following information before returning this form with the correct medication.

Student Name: _____ Date Of Birth: _____

Parent/Guardian Name: _____

Home Phone: _____ Work Phone: _____

Please list any allergies: _____

Prescription Medications

Name of Medication: _____

Prescribing Physician: _____

Condition being Treated: _____

Dosage and Form of Medication: _____

Possible Side Effects: _____

When to Administer Medication: _____

Name of Medication: _____

Prescribing Physician: _____

Condition being Treated: _____

Dosage and Form of Medication: _____

Possible Side Effects: _____

When to Administer Medication: _____

As the parent/guardian of the above stated student, I hereby hold Peak Physical Therapy, Episcopal School and the certified athletic trainer harmless in the administering of the above noted prescription medication(s). I understand that Peak Physical Therapy, Episcopal School and the certified athletic trainer accept no responsibility for medications that are defective, either by their design or dosage recommendations.

Parent/GuardianSignature: _____ Date: _____

***One form is to be filled out for each medical condition requiring medication.
This authorization shall remain effective until the end of the 2005 / 2006 school year.**