**BITTERROOT VALLEY MILITARY PROGRAM**

**AUTHORIZATION FOR MEDICAL TREATMENT**

**PART III: *Permission to Dispense Prescription Medication (If not completed, Participants will not receive medication)***

I request and authorize that my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, be administered the following prescription.

medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_per the medical doctor’s instructions on the original and un-expired pharmacy label. I certify that my child has a valid health reason for taking the medication during the Bitterroot Valley Military Program Activities.

This permission is valid from:

(Beginning date) \_\_\_\_\_\_\_\_\_\_to (ending date) \_\_\_\_\_\_\_\_\_\_.

Parent or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

**PART IV: Medication Administration Record**

Medication Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength \_\_\_\_\_\_\_\_\_\_\_\_\_

Form of Medication: \_\_\_ Liquid \_\_\_\_Tablet \_\_\_Aerosol \_\_\_Ointment \_\_\_ Other

Dosage & Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength \_\_\_\_\_\_\_\_\_\_\_\_\_

Form of Medication: \_\_\_ Liquid \_\_\_\_Tablet \_\_\_Aerosol \_\_\_Ointment \_\_\_ Other

Dosage & Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength \_\_\_\_\_\_\_\_\_\_\_\_\_

Form of Medication: \_\_\_ Liquid \_\_\_\_Tablet \_\_\_Aerosol \_\_\_Ointment \_\_\_ Other

Dosage & Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength \_\_\_\_\_\_\_\_\_\_\_\_\_

Form of Medication: \_\_\_ Liquid \_\_\_\_Tablet \_\_\_Aerosol \_\_\_Ointment \_\_\_ Other

Dosage & Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_