Summer Discovery 2017

Check one: ___ K-2 ___ 3-5 ___ 6-9

MADISON COUNTRY DAY SCHOOL
SUMMER DISCOVERY PROGRAM 2017

Phone: (608) 850-6000 Fax: (608) 850-6006

REQUEST FOR ADMINISTERING NON-PRESCRIPTION MEDICINE

Parent or Guardian Statement:

I request that ________________________________ receive the medication listed below for the
(Child's Name)

period from ________________ to _________________ .
(Date) (Date)

The medicine is to be provided by the parent in the original container. Please write the child's name on the container.

Name of Drug: ____

Dosage: ____

Time of Day to be Given: ____
(If noon, please indicate if it should be given before or after lunch.)

Illness or Reason for Medication: ____

____

I agree to hold both Madison Country Day School and their authorized personnel harmless in any and all claims arising from the administration of this medicine.

Parent/Guardian Signature: ____

Date: __________________ Daytime telephone: ____________________________________