



## High School Retreat

NAME OF STUDENT:
RETREAT DATE:

**Medications:** List all medications, prescription and over-the-counter, that the student currently takes at home and during the school day. Include all as-needed and emergency medications. Medications not authorized for self-carry must be in original container and given to the designated supervisor.

MEDICATION:	DOSAGE:	ROUTE: HOW GIVEN:	FREQUENCY:	START DATE:	STOP DATE:	SIDE EFFECTS:
1.						
2.						
3.						

### MEDICAL PROVIDER CONSENT: REQUIRED FOR PRESCRIPTION MEDICATIONS LISTED ABOVE

I Authorize the School/Parish to Give the Above Prescription Medication(S) to this Student.

PRINT MEDICAL PROVIDER NAME:	PHONE:
MEDICAL PROVIDER SIGNATURE:	DATE:

**Inhaler and Epi-Pen Only:** This student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self-administer. Yes  No