ENGINEERING INNOVATION

Reimagining Engineering—One Future at a Time

JOHNS HOPKINS WHITING SCHOOL of ENGINEERING

PRESCRIPTION MEDICATION FORM

Student Name: _____

To ensure your student's safe and successful participation in Explore Engineering Innovation, Sustainable Energy Engineering, or ISPEED BME, we ask that you provide information regarding any medication(s) that the student may take.

Your student should bring sufficient doses of prescription medication, as well as over-the-counter medicine, to last the duration of the program. Your student will be responsible for storing their own medication and taking medications according to prescriptions. Any medication that is shared or sold is grounds for immediate dismissal from the Johns Hopkins Program with no refund.

Please list all medications that the student takes, including the dosage and timing below. This must be verified and signed by the student's medical provider.

To complete this process, follow the steps below:

1. **Complete and have the student's physician verify and sign the form below.**

2. **Upload a copy of the form to the MS Form link found on the Engineering Innovation website for admitted students in your modality:**

   For Residential Students: https://ei.jhu.edu/students/admitted-residential-students/

   For Commuter Students: https://ei.jhu.edu/students/admitted-commuter-students/

   The student's JHED login credentials will be required in order to access the MS Form.

Medication Name	Dosage	Frequency (morning, evening, as needed, etc.)	Notes / Reason for taking medication

Medical Provider's Information:

Name: _____

Address: _____

City: _____State: _____Zip Code:_____

Phone: _____Fax: _____

By signing below, I acknowledge that I have reviewed the list of prescription medications, that it is complete and accurate, and that I intend to be bound my signature. I understand and agree that a photograph and/or scanned copy of my signature has the same legal validity and effect as a manual signature and that Johns Hopkins University may rely on it as such.

Medical Provider's Signature _____ Date:_____

Medical information contained on this form and otherwise collected as part of enrolling in the Program will be shared with the site residential director and the office administrative staff. Information will be shared on a need-to-know basis with instructors, teaching fellows, teaching assistants, and resident coordinators. In the event your student needs to see a medical professional off site, this information will be shared with treating medical professionals so that appropriate care may be provided. Support staff will also have access to this information for review prior to the program as well as for clerical purposes of filing and keeping a student record up to date. Medical information may also be shared with local enforcement agencies in the event of outbreaks or investigation.

Information regarding a student's special needs, prior or present psychological counseling, physical, social, emotional, medical, nutritional, or educational requirements must be communicated in writing on this form and is treated in a confidential and professional manner. Receiving relevant background information allows the Johns Hopkins and residential life staff to remain informed about potential or ongoing concerns so they can be the best resource possible for all students. Failure to disclose this information may result in the student's dismissal from the Johns Hopkins program with no refund.

By signing below, I acknowledge that I have reviewed the list of prescription medications and it is complete and accurate, and that I intend to be bound my signature. I understand and agree that a photograph and/or scanned copy of my signature has the same legal validity and effect as a manual signature and that Johns Hopkins University may rely on it as such.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date:_____