

AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Program Name	_____	Participant Name	_____
Date(s)	_____	Address	_____
Location(s)	_____	City	_____
		State/Zip Code	_____
Parent/Guardian Name	_____	Date of Birth	_____
Telephone	_____	Gender	_____

This form must be completed fully in order for the participant identified above ("Participant") to self-administer prescription medication during the program identified above ("Program"). A separate form must be completed for each medication to be administered. Self-administration of medication requires the written authorizations (below) of a licensed health care professional and Participant's parent or legal guardian.

No, my child does not need to take any prescription medication during the Program

Yes, my child will need to take a prescription medication during the Program.

All prescription medications, including medications for conditions such as food, drug, or insect allergies; diabetes; asthma; or epilepsy may be brought to the Program under the condition that Participant can self-manage care and delivery of medication. Prescription medication must be in its original container labeled with the minor's name, medication name, dosage, and time/frequency of administration.

<u>AUTHORIZATION FROM PRESCRIBER FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION</u>			
Medication name	_____		
Dosages	_____		
Condition(s) for which medication is being administered	_____		
Specific directions (e.g., on empty stomach, with water)	_____		
If PRN, frequency	_____		
If PRN, for what symptom(s)	_____		
Relevant side effect(s)	_____		
Medication shall be administered	From	_____	To _____
Special storage requirements	_____		
Is Participant capable of self-managed care	YES	NO	
<i>I hereby affirm that Participant has been instructed in the proper self-administration of the above-described medication.</i>			
Prescriber's name	_____		
Prescriber's signature	_____		
Date	_____		

I hereby authorize and recommend Participant to self-administer the above-described medication. I also affirm that Participant has been instructed in the proper self-administration of the above-described medication by his/her physician.

Signature of Participant's Parent or Legal Guardian _____

Printed Name of Participant's Parent or Legal Guardian _____

Date _____