FORM B1

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.

AUTHORIZATION FROM PRESCRIBER FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION				
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 hereby affirm that Participant has been instructed in the proper self-administration of the above-described medication.				
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 ______________________