Medication Management Form:
Authorization, Waiver, and Consent for Self-Administration of Prescription Medication

PROGRAM INFORMATION

Program Name (hereafter "Program"): _____

Date(s): _____

Location: _____

Times: _____

PARTICIPANT INFORMATION

Participant Name (hereafter "Participant"): _____

Parent/Legal Guardian Name: _____

This form **must be completed fully** in order for Participant to self-administer required medication.

A new medication administration form must be completed for **each Program** attended by Participant, for **each medication**, and **each time** there is a change in dosage or time of administration of a medication.

Self-medication for prescription medications requires a parent's signature.

Please sign and select one:

☐ **NO, my child does not need to take any prescription medication while at the Program.**
Signed:

☐ **Yes, my child will need to take prescription medication while at the Program.**
Signed:

- 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 the participant can self-manage care and delivery of medication with written authorization to do so at the Program.
- Prescription medication must be in its original container labeled by the pharmacist or prescriber.
- Label must include the name, address and phone number for pharmacist or prescriber.
- Containers must hold only the amount required for the time the participant will be attending the Program.
- It is Participant's responsibility to request their medications.
- If Participant is unsure of the medication to take or the correct dosage, Program staff will contact the parent or guardian for clarification.

PARENTAL AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication Name: _____

Dosage: _____

Condition for which medication is being administered: _____

Specific Directions (e.g., on empty stomach/with water, etc.): _____

Time/frequency of administration: _____

If taken "as needed", frequency: _____

If taken as needed, for what symptoms: _____

Relevant side effects: _____

Medication shall be administered from: _____ to _____

Special Storage Requirements: _____

Is refrigeration required? ☐ **YES** ☐ **NO**

Is the participant capable of self-managed care? ☐ **YES** ☐ **NO**

Prescriber's Name/Title: _____

Prescriber's Place of Employment: _____

Prescriber's Telephone: _____

☐ Participant will not be picked up by a parent/guardian at the end of the Program. I give my permission for Participant's medication to be released to Participant or to the adults authorized to pick up the Participant at the end of the Program.

Please initial: _____

I authorize and recommend self-medication by Participant for the above medication.

I also affirm that Participant has been instructed in the proper self-administration of the prescribed medication by their attending physician.

I shall indemnify and hold harmless the Youth Program, Youth Program Personnel, Auburn University; its Board of Trustees, individually and collectively; Administrators; Faculty; Staff; and all other officers, directors, employees, and agents against any claims that may arise relating to Participant's self-administration of prescribed medication(s).

I have legal authority to consent to medical treatment for the Participant named above, including the administration of medication at the above-referenced Program.

Parent/Guardian Name: _____

Parent/Guardian Signature:

Date: _____

A PARENT OR GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 19