SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION FORM

PROGRAM/CAMP INFORMATION

Program/Camp Name:_____(hereafter "Program")

Location:_____Date(s): _____

PARTICIPANT INFORMATION

Participant's Name:_____(hereafter "Participant")

Participant's Age: _____

This form must be completed fully in order for participants to self-administer required medication. A new medication administration form must be completed for each Program attended by the participant, for each medication, each time there is a change in dosage or time of administration of a medication and/or at three month intervals. Self-medication requires licensed health care authorization and signature, and parent signature.

☐ My child will need to take prescription medication while at the Program.

☐ My child needs to keep this medication with him/her at all times for emergency care.

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 by a licensed health care provider. Prescription medication must be in its original container labeled by the pharmacist or prescriber. The label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only standard dose vials or the amount required for the time the participant will be attending the program.

AUTHORIZATION FOR SELF-ADMINSITRATION OF PRECRIPTION MEDICATION

Medication Name:_____ Dose: _____

Condition for which medication is being administered: _____

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

Time/Frequency of administration: _____

If as needed, for what symptoms?_____

Relevant side effects: _____

Medication shall be administered from: date:_____ to date: _____

Special Storage Requirements: _____

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

Prescriber's Name/Title: _____

Address: _____

Telephone:_____ Fax:_____ Email: _____

I hereby affirm that this individual has been instructed in the proper self-administration of the prescribed medication(s).

Prescriber's Signature:_____ Date: _____

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician or other health care provider. I, further, on behalf on my heirs, executors, administrators, and assigns release the Unviersity from any and all causes of actions, and further waive any and all claims against the University, the Commonwealth of Virginia, and their officers, employees, and agents relating to my child's self- administration of the prescribed medication(s).

Parent/Guardian Name :_____

Parent/Guardian Signature:_____ Date:_____