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-ADMINISTRATION OF PRESCRIPTION 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: ___________________________ 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 of my heirs, executors, administrators, and assigns release the University 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: ___________________________