UNIVERSITY OF CINCINNATI
Guardian Authorization, Waiver and Consent for Self-Administration of Prescription Medication Form

PROGRAM/ACTIVITY/CAMP INFORMATION

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

Date(s): _____ **Time(s):** _____ **Location:** _____ **PARTICIPANT**

INFORMATION

Participant Name: _____ (hereafter "Participant")

Parent/Legal Guardian Name (if applicable): _____

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, and each time there is a change in dosage or time of administration of a medication. Self-medication requires licensed health care authorization and signature, *and* parent signature.

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

☐ **Yes, my child will need to take prescription medication while at 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 the participant can self-manage care and delivery of medication with written authorization to do so at camp by a licensed health care provider. 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.

PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication Name_____

Dose:_____

Condition for which medication is being administered:_____

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

Time/Frequency of administration:_____

If PRN, frequency:_____

If PRN, for what symptoms:_____

Relevant side effects:_____

Medication shall be administered from (date_____to _____

Special Storage Requirements:_____

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

Prescriber's Name/Title: _____

Prescriber's Place of Employment: _____ Telephone: _____

Fax: _____

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. I shall indemnify and hold harmless the Program Staff, University of Cincinnati, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my child's self-administration of prescribed medication(s). ***I/We 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** _____