

**YOUTH PROGRAM/CAMP
PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT
FOR SELF-ADMINISTRATION
OF PRESCRIPTION MEDICATION FORM**

PROGRAM INFORMATION

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

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

PARTICIPANT INFORMATION

Participant Name: _____ (here "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 route 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.

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, Wilkes University, 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/Guar