MEDICATION PRESCRIBER/ PARENT AUTHORIZATION

UNIVERSITY OF NORTHERN COLORADO

CAMP/ PROGRAM INFORMATION

Camp/ program Name _____

Date(s) _____ - _____ Time(s) _____

PARTICIPANT'S INFORMATION

Participant's Name _____Parent/ Legal Guardian (if applicable) _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth ___ / ____ / ____ Gender: M/F

___ No, my child does not need to take any medication while at camp/ during program/ trip

___ Yes, my child will need to take medication while at camp/ during program/ trip (check one):

___ Prescription Medication ___ Over-the-Counter Medication

**This form must be completed fully in order for participants to administer required medication to themselves. A new medication administration form must be completed for each camp/ program attended by the participant, and each time there is a change in dosage or time of administration of a medication. This authorization requires a licensed health care authorization and signature, and parent signature.**

- Prescription medication must be in its original container labeled by a pharmacist or prescriber. Label must include the name, address and phone number for the pharmacist or prescriber.
- Containers must hold only the amount required for the time the participant will be attending the camp/ program.
- All prescription medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought 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.

PRESCRIBER AUTHORIZATION FOR SELF- ADMINISTRATION FOR PRESCRIPTION MEDICATION

Medication Name _____ Dose _____

Condition for which medication is being administered _____

Specific Directions (e.g. on empty stomach/ with food etc.) _____

Time/ frequency of administration _____

If PRN, frequency _____

If PRN, for what symptoms _____

Relevant side effects _____

Medication shall be administered from ____ / ___ / ___ 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 _____

---

PARENT/ GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR SELF – ADMINISTRATION OF PRESCRIPTION MEDICATON

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 hereby release and discharge, indemnify and hold harmless the Board of Trustees for the University of Northern Colorado, its Trustees, officers, employees, agents, representatives, instructors, volunteers, and the State of Colorado (the "Released Parties") from and against all claims, demands, and causes of action whatsoever, either in law or in equity, relating to injury, disability, death or other harm, to any person or property or both, 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 camp/ program.

Parent / Guardian Signature _____ Date _____

Home Phone _____ Cell Phone _____ Work Phone _____