The W Mississippi University for Women
A Tradition of Excellence for Women and Men

Authorization for Self-Administration of Prescription Medication

PROGRAM/CAMP NAME: _____

DATE(S): _____ TIME(S): _____

LOCATION: _____

NAME OF PARTICIPANT: _____ €MALE €FEMALE

DATE OF BIRTH: _____ SS#: _____

ADDRESS: _____ CITY: _____ STATE: _____

PHONE #: _____ EMAIL: _____

This form must be completed fully in order for the participant identified above "Participant" to self-administer prescription medication during the program identified above ("Program"). **A separate form must be completed for each medication to be administered.** Self-administration of medication requires the written authorizations (below) of a licensed health care professional and Participant's parent or legal guardian.

_____ **No, my child does not need to take any prescription medication during the Program.**
_____ **Yes, my child will need to take a prescription medication during 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 Participant can self-manage care and delivery of medication. Prescription medication must be in its original container labeled with the minor's name, medication name, dosage, and time/frequency of administration.

AUTHORIZATION FORM PRESCRIBER FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication name: _____

Dosages: _____

Condition(s) for which medication is being administered: _____

Specific directions (e.g., on empty stomach, with water): _____

Time/frequency of administration: _____

If PRN, frequency: _____

If PRN, for what symptom(s): _____

Relevant side-effect(s): _____

Medication shall be administered from _____ to _____

Special storage requirements: _____

Is participant capable of self-managed care? _____

I hereby affirm that Participant has been instructed in the proper self-administration of the above-described medication.

Prescriber's Name: _____

Prescriber's Signature: _____ Date: _____

I hereby authorize and recommend Participant to self-administer the above-described medication. I also affirm that Participant has been instructed in the proper self-administration of the above-described medication by his/her physician.

Signature of Participant's Parent or Legal Guardian: _____

Printed Name of Participant's Parent or Legal Guardian: _____

Date: _____