MEDICATION ADMINISTRATION RELEASE FORM

Child's Name: ________________________________ DOB: __________Grade: _______

This release is valid only for dates: ______________________to_____________________.

This form must be completed fully for the Carmel Youth Center to administer the required medication. A new medication administration form must be completed at the beginning of each program enrollment period each year, for each medication, and each time there is a change in dosage or time of administration of a medication.

*Prescription medication must be in a container labeled by the pharmacist or prescriber.

*Non-prescription medication must be in the original container with the label intact.

*An adult must bring the medication to the CYC.

PRESCRIBER'S AUTHORIZATION

Condition for which medication is being administered: ____________________________________

Medication Name: ____ Dose: __________

Route: ___________ Time/frequency of administration: __________________________________

If PRN, frequency: _________________If PRN, for what symptoms:________________________

Relevant side effects: _____________None expected _______ Specify: _______________________

Medication shall be administered from: ______________to ______________Month/Day/Year

Prescriber's Name/Title: ____

Telephone: _______________________________ Email: _______________________________

Address: ____

Prescriber's Signature: _____________________________________ Date: ________________
(Original signature or signature stamp ONLY) Month/Day/Year

(Use for Prescriber's Address Stamp)

A verbal order was taken by the CSN/RN for the above mediation on (Date): __________

(Name): __________________________

PARENT/GUARDIAN AUTHORIZATION

I/We request CYC to administer the medication as prescribed by the above prescriber. I/We certify that I/We have legal authority to consent to medical treatment for the child named above, including the administration of medication at CYC. I/We understand that at the end of the camp or program session, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the CYC Executive Director to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: __________________________________ Date: _______________

Home Phone #: ________________ Cell #: _________________Wk Phone#: ______________

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL-Self carry/self-administration of **emergency** medication may be authorized by the prescriber and must be approved by the CYC according to the State medication policy.

Prescriber's authorization: ____
Signature Date

Order reviewed by the CYC Executive Director: ______________________________________
Signature Date