FORM B1

AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Program Information

Program Name: ________________________________

Date(s): ______________________________________

Location(s): ___________________________________

[Note: The program information should be filled in by the Program Director]

Participant Information

Participant Name: ______________________________

Address:_______________________________________

City, State, Zip Code: ___________________________

Date of Birth: __________________________________

Gender: _______________________________________

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 FROM 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: ____