

AUTHORIZATION FOR STUDENTS TO SELF-CARRY MEDICATION TO YOUTH PROGRAMS AND SUMMER CAMPS

Please return completed form to Terry Thies at tthies@parkland.edu

Please fill out and complete both sections.

Student's Name: _____ **School year:** _____

To Be Completed by Prescribing Health Professional

It is my professional opinion that _____

Is capable of carrying and self-administering the following medication:

Medication Name: _____

Dosage: _____

Frequency: _____

I recommend self-administration of this medication for the treatment of: _____

Special Instructions or comments: _____

Health Care Provider Signature

Date

Print Name

Phone

To Be Completed by Parent / Guardian

I, request and authorize my child _____ to carry and/or self-administer their _____ medication.

This authorization is based on the following:

- I hereby give permission to my child to self-administer prescribed medication at camp or class.
- I authorize release of information related to my child's health / medications between the Community Education and the prescribing health care provider.
- I understand that my child shall be permitted to carry their medication at all times providing they do not misuse.
- I understand that if my child misuses the Medication, staff will take the medication and terminate this agreement.
- I understand that this authorization shall be effective for the duration of the registered class or camp and must be renewed annually.

Parent / Guardian Signature

Date