JAMES MADISON UNIVERSITY

Office of Youth Safety
Self-Administration Authorization of Medication Form

PROGRAM/EVENT/CAMP (PEC) Name: _____ Date(s): _____

This form must be completed fully in order for PECs to administer the required medication. A new medication administration form must be completed for each PEC attended, for each medication, and each time there is a change in dosage or time of administration of a medication. Self-medication requires licensed health care authorization and signature, and parent signature. It is NOT permissible for the minor participant to share any medications with any other participants or with staff. It is the responsibility of the parent(s)/legal guardian(s) to be sure that their minor participant's medications brought to the PEC are not left behind at the end of the PEC. Failure to do so will result in the medications being destroyed within three working days after the minor participant's last day at the PEC. Absolutely no medications will be returned via mail regardless of the circumstance.

* 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 PEC.
* All medication must be securely kept by the PEC program director/or designee at all times while in attendance.

MINORS PRESCRIBER'S AUTHORIZATION

Minor Name: _____ Date of Birth: _____

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 _____

Medications shall be administered from: Date_____ to Date: _____

Prescriber's Name/Title: _____

Address: _____

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

All prescription medications may be brought to the PEC under the condition that the participant can self-manage care and delivery of medication. Written authorization from a licensed health care provider is required to self-administer any medication. The University is not responsible for the safekeeping of medication held by the participant.

I authorize self-medication by my child for the above medication. I also affirm that they have been instructed in the proper self- administration of the prescribed medication by their attending physician or other health care provider. I, further, on behalf on my heirs, executors, administrators, and assigns release the University from any and all causes of actions, and further waive any and all claims against the University, the Commonwealth of Virginia, and their officers, employees, and agents relating to my child's self- administration of the prescribed medication(s).

Parent/Guardian Full Name : _____

Parent/Guardian Signature: _____ Date: _____

Home Telephone #: _____ Cell Telephone #: _____ Work Telephone # : _____

A copy should be maintained by PEC/Supporting Unit following Policy 1109-Records Management.

Self- Administration Medication Log for PEC Minor Participant*

Minor Participant's Name: _____ D.O.B_____

DATE	MEDICATION	DOSE	TIME	OBSERVED BY	Adverse Reactions/ Medication Errors

*The log should be filled out only at the time of administration and not pre-populated.

A copy should be maintained by PEC/Supporting Unit following Policy 1109-Records Management.