Medication Management Form

Instructions

Prescription or over-the-counter (OTC) 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 the medications will be secured by program staff and made available to participant for self-administration as authorized in writing by the participant's parent/guardian. It is the participant's responsibility to come to get their medications, but program staff will make every effort to remind them as needed. If the participant is unsure of the medication to take or the correct dosage, program staff will contact the parent or guardian for clarification.

Medication must be in its original container and all labels must be intact with instructions clearly legible. Prescription medications must be labeled by the pharmacist or prescriber, with the name, address and phone number for pharmacist or prescriber. It is advised that containers hold only the amount required for the time the participant will be attending the Program. If a tablet should be cut in half, this should be done before the submitting medication to the Program. Please send medicine cups for liquid medications.

All medications for a single participant should be stored in a plastic bag labeled with the participant's name and date of birth. All medications and medication bags will be returned to the participant's parent/guardian when the program is over. This form must be completed fully in order for participants to self-administer required prescription or OTC medication. A new Medication Management form is required for each program attended by the participant, each medication, and each time there is a change in dosage or time of administration of a medication.

Note: Unless we have prior parental authorization, we cannot provide ANY OTC medications.

Medication Management Form

Participant Name: _____

Program/Activity Name: _____ Program Date: _____

Medication Information

Medication Name: _____ Dose: _____

Condition for which medication is being administered: _____

Specific Directions (e.g., on empty stomach/with water, taken with food, etc.): _____

_____

Time/frequency of administration: _____

If taken as needed, frequency: _____

If taken as needed, for what symptoms: _____

Relevant side effects: _____

Medication shall be administered from (date): _____ to _____

Special Storage Requirements:

Is refrigeration required? ___Yes ___No

Prescriber's Name/Title:

Prescriber's Place of Employment: Telephone:

If your child requires any assistance with their medications, please explain:

Authorization

- I authorize and recommend self-administration by my child for the above medication. (Please initial: _____)
- I also affirm that they have been instructed in the proper self-administration of the prescribed medication by their attending physician. (Please initial: _____)
- I shall indemnify and hold harmless the Program Staff, The University of Alabama, its Board of Trustees, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my child's self-administration of prescribed medication(s). (Please initial: _____)

Signature of Parent or Guardian: _____Date:_____

Parent or Guardian Name: _____

Work Phone: _____ Cell Phone_____