YOUTH PROGRAM MEDICATION RELEASE AUTHORIZATION FORM

Program/Camp Name: (hereafter "Program")

Date(s):

Location:

PARTICIPANT INFORMATION

Participant Name: (hereafter "Participant")

Participants Age:

All participants must submit this form prior to the start date of the Program. The Program advised that families make a copy of these forms for their own records. All health and medical information is confidential and will not be released, unless legally required, without consent and is not used to discriminate, to deny healthcare, or to affect admission status. Participants must be able to self-administer all prescription and non-prescription medications. The Program does not assist participants in taking their prescription or non-prescription medications, nor does the Program remind participants to do so.

Select Over-the-Counter (OTC) medication may be administered, if we have written permission from the Participant's parent or guardian. **Note: Unless we have parental authorization, we will not administer ANY medications or make OTC medications available to participants unless necessary as part of general first-aid treatment.** I give permission for the Program staff to administer the following medications to my Participant consistent with medication directions, if the need arises. Check all that apply.

☐ No, my child does not take prescription medication while at the Program.

☐ Yes, my child will need to take prescription medication while at the Program.

All prescription medications, including medications for conditions such as food, drug, or insect allergies; diabetes; asthma; or epilepsy may be brough to the Program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so at the Program by a parent/legal guardian. Prescription medication must be in its original container labeled by the pharmacist or prescriber.

Please list all prescription medications:

Non-Prescription Medications

In the event of minor injuries or ailments participants may incur during the program, Program staff will provide the following over-the-counter medications (or their generic equivalents) for the symptoms indicated after checking this form and attempting to contact a participant's parent/ legal guardian.

I give permission for the Program staff to administer the following medications to my Participant consistent with medication directions, if the need arises. Check all that apply.

☐ Tylenol (acetaminophen) for pain or headache

☐ Tums, Rolaids, or Pepto-Bismol for upset stomach

☐ Ibuprofen for pain or menstrual cramps

☐ Robitussin or cough drops for cough

☐ Sudafed PE for sinus congestion

☐ Band-aids, antiseptic wipes, Neosporin, gauze, latex gloves for cuts or scrapes

☐ Other: _____

☐ Allergies to common medications: _____

Permission to Provide Medication

I give permission to provide the above-identified medications to my child. I authorize and recommend self-medication by my child for all medications identified above. I also affirm that he/she has been instructed in the proper self-administration of the above-identified medications by his/her attending physician (for prescription medications) and by a physician and/or parent/legal guardian (for non-prescription medications). I/We have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the above referenced Program.

I certify that the foregoing information is true and complete to the best of my knowledge. I acknowledge that Program staff will rely on the information provided herein to provide medications to my child. To ensure the safety of each participant, I understand that the information I am providing will be available to appropriate Program staff and medical professionals working with this participant, to utilize with discretion.

Indemnification and Release

I agree to defend, indemnify and hold harmless the Program Staff, Northwestern University, its Board of Trustees, Administration, Faculty, Staff, and all other officers, directors, employees and agents against any claims, including but not limited to personal injuries and death, that may arise relating to my child's self-administration of medication(s).

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____