AUTHORIZATION FOR MEDICATION ADMINISTRATION

Only complete this form if the Participant requires medication to be given at Ohio University

Participant Name: _____

Date of Birth ____/____/____

1. I hereby give my permission for authorized Program personnel to administer the below medication as directed by our physician.
2. I will send the medication to Ohio University in the ***original container*** in which it was dispensed by the doctor or pharmacist.
3. I agree to notify the Program staff immediately if there is any change to the information below.
4. I release and agree to hold Ohio University, its governing board, officers, agents, employees, and any students acting as employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____

Parent/Guardian Signature Address

_____ _____

Printed Name Cell Phone Work Phone

Physician's orders for the administration of medication by Program staff

_____ is under my care and should receive the following medications while at the Program:

Participant's name

Medication	Dosage	Time Schedule
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reason for medication(s): _____

_____

Any possible side effects: _____

_____

Special Instructions: _____

_____

_____

_____ _____

Licensed Physician Signature Address

_____ _____

Printed Name Phone