AUTHORIZATION FOR MEDICATION ADMINISTRATION

Only complete this form if your child requires medication to be given at Ohio University
If medication will be administered this form MUST be turned in before your child can participate.

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 that is not expired 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

_____
Printed Name

PHYSICIAN'S ORDERS FOR THE ADMINISTRATION OF MEDICATION BY PROGRAM STAFF

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

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

Reason for medication(s): _____
_____

Any possible side effects: _____
_____

Special Instructions: _____
_____
_____
_____
_____

_____ _____
Licensed Physician Signature Address

_____ _____
Printed Name Phone