AUTHORIZATION TO ADMINISTER MEDICATION

I. Personal/Medication Information (please print)  
Today’s Date: ___/___/_____  
Child’s Name: _____________________________  Age: ______________
Food/Drug Allergies: ________________________________________________
Parent/Guardian Name: _______________________________________________
Home Phone: _____________________________  Cell Phone: _________________________
Work Phone: _________________________________________________
Name of Licensed Prescriber: __________________________________________
Phone Number: _____________________________
Medication: ________________________________________________________
Dosage: __________________________________________________________________
Instructions (route, frequency, duration, take with food, etc.): ________________
________________________________________________________________________
________________________________________________________________________
Quantity Received: ______________________________________________________
Special Storage Instructions: _____________________________________________

II. Authorization for Medical Care

I hereby authorize the program staff to administer my child the above-listed medication. I understand that medication, whether over-the-counter or prescription, should be kept in original containers. Prescription medication containers should bear the pharmacy label, date of filling, pharmacy name and address, patient name, name of prescribing practitioner, name of prescribed medication, directions for use and cautionary statements, as originally appeared on the container. When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

By signing this form I hereby acknowledge that all information is accurate and current, that all pertinent and important medication information is listed on this form, and to the best of my knowledge, my child is capable of participating safely in the program. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this program. I agree to notify the program of any changes in the above information in a timely and reasonable manner.

I hold harmless and agree to indemnify the program and The University of North Georgia, as well as the Board of Regents, from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment.

Signature of Parent or Guardian: ____________________________________________

Parent or Guardian Name: __________________________________________________

If you need this document in another format, please contact the UNG ADA Coordinator at ada@ung.edu.