UNIVERSITY OF MICHIGAN

CHILDREN ON CAMPUS

SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION FORM

PROGRAM/CAMP INFORMATION

Program/Camp Name: (hereafter "Program")

Location: Date(s):

PARTICIPANT INFORMATION

Participant's Name: (hereafter "Participant")

Participant's Age:

This form must be completed fully in order for participants to self-administer required medication. State law requires that a written emergency care plan must be on file that is "prepared by a licensed physician in collaboration with the minor child and the minor child's legal parent or guardian, and that is updated as necessary for changing circumstances." A new medication administration form must be completed for each Program attended by the participant, for each medication, each time there is a change in dosage or time of administration of a medication and/or at three month intervals. Self-medication requires licensed health care authorization and signature, and parent signature.

All prescription 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 participant can self-manage care and delivery of medication with written authorization to do so by a licensed health care provider. Prescription medication must be in its original container labeled by the pharmacist or prescriber. The label must include the name, address and phone number for pharmacist or prescriber. Containers must hold only standard dose vials or the amount required for the time the participant will be attending the Program.

PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication Name: Dose:

Condition for which medication is being administered:

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

Time/Frequency of administration:

If as-needed, for what symptoms?

Relevant side effects:

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

Special Storage Requirements:

Is the participant capable of self-managed care ☐ YES ☐ NO

Prescriber's Name/Title:

Address:

Telephone: Fax: Email:

I hereby affirm that this individual has been instructed in the proper self-administration of the prescribed medication(s).

Prescriber's Signature: Date:

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician or other health care provider. I indemnify and hold harmless the Program Staff, the University of Michigan, and the University's employees and agents against any claims that may arise relating to my child's self-administration of the prescribed medication(s).

Parent/Guardian Name

Parent/Guardian Signature: Date: