AUTHORIZATION TO ADMINISTER MEDICATION
(To be completed by parent/guardian)

Name of Child:_____Age: _____
Food/Drug Allergies: _____
Diagnosis (at parents' discretion): _____
Emergency Telephone: _____

Parent/Guardian Name: _____
Home Telephone: _____
Cell Phone: _____
Name of Licensed Prescriber:_____
Business Telephone: _____

Section A: Authorization to Administer by WRWA Personnel

I hereby authorize program leaders from the Westport River Watershed Alliance to administer the medications below as directed to my child.

Medication	Dosage	Dosage schedule	Condition Requiring Meds	Side effects	Special storage requirements	Special Instructions

Additional Comments:

_____

Parent/Guardian Signature:_____ **Date:** _____

Section B: Authorization to Self-Medicate

Please complete if your child will be bringing an Epipen, inhaler, or insulin and you wish for him/her to administer it independently.

My child has a physical condition which requires him/her to routinely receive medication as quickly as possible in order to avoid a medical crisis or to manage his/her medical condition. In the interest of his/her personal well being, I hereby grant my child the authority to carry the medication or medications listed below and to self-administer it as directed by the prescribing physician when needed.

Medication	Dosage	Dosage schedule	Condition Requiring Meds	Side effects	Special storage requirements	Special Instructions

Additional Comments:

_____

Parent/Guardian Signature:_____ **Date:** _____