MEDICATION ADMINISTRATION AUTHORIZATION FORM

City of Vacaville
Community Services Department
40 Eldridge Ave., Suite 13
Vacaville, CA 95688
(707) 449-5658

This form must be completed fully in order for staff members to administer the required medication or for the youth participant to self administer medication. A new medication administration form must be completed at the beginning of each program session, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.**
- **An adult must bring the medication to the camp and give the medication to an adult staff member.**

PROGRAM INFORMATION

PROGRAM NAME		
PHYSICAL ADDRESS		
CITY	STATE	ZIPCODE

PRESCRIBER'S AUTHORIZATION

CHILD'S NAME			DATE OF BIRTH
CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:			EMERGENCY MEDICATION [ ] YES [ ] NO
MEDICATION NAME	DOSE		ROUTE
TIME/FREQUENCY OF ADMINISTRATION	IF PRN, FREQUENCY		
IF PRN, FOR WHAT SYMPTOMS			
KNOWN SIDE EFFECTS SPECIFIC TO CHILD			
MEDICATION SHALL BE ADMINISTERED *(NOT TO EXCEED 1 YEAR)*	FROM		TO
PRESCRIBER'S NAME/TITLE	This space may be used for the Prescriber's Address Stamp		
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIPCODE	
PRESCRIBER'S SIGNATURE ***(Parent cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*			DATE

PARENT/GUARDIAN AUTHORIZATION

I request that City of Vacaville personnel administer the medication or supervise the youth participant in self administration if authorized as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded. I authorize City of Vacaville personnel to communicate with the prescriber as allowed by HIPAA.

PARENT/GUARDIAN SIGNATURE		DATE
HOME PHONE #	CELL PHONE #	WORK PHONE #

AUTHORIZATION FOR SELF ADMINISTRATION AND SELF CARRY

I consent that the child named above is able to self administer the medication listed. I authorize self administration of the above listed medication for the child named above under the supervision of City of Vacaville personnel. The child named above may self carry emergency medication if indicated below.

PRESCRIBER'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE
PARENT/GUARDIAN'S SIGNATURE	SELF CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] Not emergency medication	DATE