Plainfield UMC Youth Ministries
Medication Authorization Form

Student Name (Last, Middle, First)

Date Of Birth | Grade In School

Parent/Guardian Name | Parent/Guardian Name

Address

City, State, Zip Code

Primary Phone (Parental) | Secondary Phone

Prescription medications may be administered at Youth Ministry Events as authorized on this form. No prescription medication may be administered at Youth Ministry Events unless both the student's physician and parent/guardian have completed, signed, and returned this form, completed in its entirety, to the Youth Director of Plainfield UMC, prior to leaving for a Youth Ministry Event. Also, Medication shall be in the original labeled container as dispensed (prescription medication) or the manufacturer's labeled container (non-prescription medication). The medication label shall contain the student's name, name of the medication, the name of the prescribing health care provider, directions for use, and date. If medication or dosage changes, parents need to notify the Youth Director, in writing, of this change.

PARENT/GUARDIAN PERMISSION AND AUTHORIZATION

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the Youth Director or his/her designee, on my behalf, to administer or to attempt to administer to my child (or allow my child to self-administer) lawfully prescribed medication and non-prescription medication in the manner described on the reverse side of this form. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual who does not have medical training, and I specifically consent to such practices. I understand that this authorization is not effective unless the Youth Director has approved the medication authorization form for my child and signed this form in the space provided on the reverse. I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against Plainfield UMC, the Youth Director, and any and all Youth Ministry Volunteers, the Bishop of the Northern Illinois Conference, or any of their employees or agents arising out of the administration or attempted administration of medications listed on this form. In addition, I agree to hold harmless and indemnify Plainfield UMC, its Employees, and Volunteers, and their employees or agents, jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from this administration or attempted administration of said medication.

Parent/Guardian (Signature) | Parent/Guardian (Signature)

Please fill out this form for **all** over the counter and prescription medications. If your teen will be bringing prescription medication on a youth event, portions of this form must be completed and signed by your teen's physician/health care provider. This form to be updated annually by parent/guardian and/or physician/health care provider.

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Medication/Health Care Treatment
(Attach separate sheet, if necessary)

Dosage/Times To Be Administered

Condition Treated

Expected Side Effects, If Any

1. Adults have permission to give this student Over-The-Counter medications for pain (acetaminophen/ibuprofen) or digestive discomfort (pink bismuth/anti-nausea/anti-diarrheal) in compliance with dosing instructions on the packaging. (Please Circle) Yes No

2. May student self-administer medication under supervision of a Youth Ministry Leader who does not have medical training?
   (Please Circle) Yes No

3. May student carry and self-administer medication on this form, without Adult Supervision?
   (Prescription birth control only)
   (Please Circle) Yes No

4. For **Asthma Rescue Inhaler, Epinepherine**, and **Insulin Only**: I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering this medication independently and without supervision.
   (Please Circle) Yes No

5. For **Asthma Rescue Inhaler, Epinepherine**, and **Insulin Only**: I also request that this student be allowed to carry the above-described medication on their person during Youth Ministry Events in order to facilitate the self-administration of the medication as needed.
   (Please Circle) Yes No

6. Please check one box for emergency medication administration:
   □ My child can self-administer the above physician-ordered emergency medication without supervision.
   □ My child can self-administer the above physician-ordered emergency medication but will require supervision or assistance.

Physician's/Prescriber's signature

Date Signed

Physician's/Prescriber's Name (PRINT)

Emergency phone number

Physician's Address City, State, Zip Code

Medication Authorization approved or denied and signed _____, 2017

By:_____
Signature of Youth Director on behalf of Plainfield UMC, 15114 S. Illinois St., Plainfield, IL 60544