June 2016

First Presbyterian Church of Libertyville
Medication Administration Consent Form

Student Name: _____ Date of Birth: _____ Grade: _____

Name of Church Event: _____

Section 1: Medical History and Prescription Medication (Please Complete in its Entirety)

Allergies: Does your child have allergies to any of the following things? Foods (nuts/dairy/etc.) _____

_____

Please describe the allergic reaction: _____

2. Medical Information: Does your child have any medical condition that we should be made aware of such as asthma, diabetes, seizures, headaches, heart disease, ADHD, etc.? Please be specific. _____

_____

3. Medicine: I give my permission for the administration of these medications. I understand that all medication must be supplied by me and will be held and administered by a designated adult unless I give consent for my child to self-administer medication.

NAME OF DRUG	DOSAGE	TIME TO BE GIVEN	SELF ADMINISTER?
_____	_____	_____	Y N initial _____
_____	_____	_____	Y N initial _____
_____	_____	_____	Y N initial _____

ALL MEDICATIONS MUST COME IN THE ORIGINAL CONTAINER AND HAVE INSTRUCTIONS AS TO WHEN THEY ARE TO BE TAKEN AND HOW THEY ARE TO BE PROPERLY STORED. ALL MEDICATIONS WILL BE HELD BY A DESIGNATED ADULT UNLESS PARENT GIVES CONSENT FOR THE STUDENT TO SELF-ADMINISTER MEDICATION. BY CONSENTING TO A PARTICIPANT'S POSSESSION OF MEDICATION THE PARENT/GUARDIAN IS RELEASING FIRST PRESBYTERIAN CHURCH OF LIBERTYVILLE AND ITS AGENTS (INCLUDING BUT NOT LIMITED TO THE LEADER AND THE DESIGNATED ADULT) FROM RESPONSIBILITY FOR THE CORRECT ADMINISTRATION OF THE MEDICATION. **ONLY PROVIDE ENOUGH MEDICATION FOR THE WEEK. DO NOT SEND EXTRA MEDICATION.**

Section 2: Over-the-Counter Medications (OTC) (please complete in its entirety)

I, the parent/guardian, give permission: (check all that apply)

- ☐ For a designated adult or adult leader to administer over-the-counter medication which will be provided by an adult.
- ☐ For my child to carry and self-administer over-the-counter medication.
- ☐ I do not give permission for my child to take over-the-counter medication

I, the parent/guardian, give permission for my child to be given the following OTC medication: (check all that apply)

- ☐ Any brand non-prescription Acetaminophen
- ☐ Any brand non-prescription Ibuprofen
- ☐ Any brand non-prescription topical antibiotic (i.e. Neosporin)
- ☐ Any brand non-prescription topical antihistamine (i.e. Benadryl cream)
- ☐ Tums, antacid, &/or antidiarrheal
- ☐ Diphenhydramine (Benadryl)
- ☐ Sunscreen
- ☐ 1% Hydrocortisone cream
- ☐ Any brand non-prescription Dramamine
- ☐ Bug Spray
- ☐ No OTC medicine may be given to my child

FOR ASTHMA, ALLERGY, OR DIABETIC MEDICATION ONLY (Inhalers, Epi-Pens, Insulin)

Student may carry medication on his/her person (circle) Y / N Student may self-administer medication (circle) Y / N

Directions for self-administration: _____

Signature of Parent/Guardian: _____ Printed Name: _____ Date: _____

FOR OFFICE USE ONLY:

Date received: _____ Date reviewed & logged: _____ Reviewer's Initials: _____

Date of check-in: _____ Notes: _____ Parent Initial: _____