FORM B1

AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Program Information

Program Name: _____
Date(s): _____
Location(s): _____

[Note: The program information should be filled in by the Program Director]

Participant Information

Participant Name: _____
Address: _____
City, State, Zip Code: _____
Date of Birth: _____
Gender: _____

This form must be completed fully in order for the participant identified above ("Participant") to self-administer prescription medication during the program identified above ("Program"). A separate form must be completed for each medication to be administered. Self-administration of medication requires the written authorizations (below) of a licensed health care professional and Participant's parent or legal guardian.

☐ **No, my child does not need to take any prescription medication during the Program.**
☐ **Yes, my child will need to take a prescription medication during the Program.**

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 Participant can self-manage care and delivery of medication. Prescription medication must be in its original container labeled with the minor's name, medication name, dosage, and time/frequency of administration.

AUTHORIZATION FROM PRESCRIBER FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication name: _____
Dosages: _____
Condition(s) for which medication is being administered: _____
Specific directions (e.g., on empty stomach, with water): _____
Time/frequency of administration: _____
If PRN, frequency: _____
If PRN, for what symptom(s): _____
Relevant side effect(s): _____
Medication shall be administered from _____ to _____
Special storage requirements: _____
Is Participant capable of self-managed care: _____

I hereby affirm that Participant has been instructed in the proper self-administration of the above-described medication.
Prescriber's name: _____
Prescriber's signature: _____
Date: _____

I hereby authorize and recommend Participant to self-administer the above-described medication. I also affirm that Participant has been instructed in the proper self-administration of the above-described medication by his/her physician.

Signature of Participant's Parent or Legal Guardian: _____

Printed Name of Participant's Parent or Legal Guardian: _____

Date: _____