VHUMC Student Ministry – Student

MEDICATION AUTHORIZATION

Valid June 1, 2018 to May 31, 2019

STUDENT INFORMATION

Student's Name: _____

Parent/Guardian Names(s): _____

Contact Phone Numbers: _____

Student DOB:_____ Age:_____ Grade:_____ Gender:_____ Weight:_____ lbs

Known Drug Allergies:_____

Other Known Allergies:_____

OVER-THE-COUNTER MEDICATION AUTHORIZATION

I, _____ (print name of parent/guardian) hereby authorize VHUMC appointed adults to administer as directed and as needed the following over-the-counter medications to _____ (print name of student).

PLEASE CIRCLE ONE

Ibuprofen	YES	or	NO	Imodium	YES	or	NO
Acetaminophen	YES	or	NO	Pepto Bismol	YES	or	NO
Benadryl	YES	or	NO				

VHUMC will stock and supply these medications on all trips.

PRESCRIPTION AUTHORIZATION

Please individually list all prescribed medications to be taken by your student.

Medication Name:_____ Dosage:_____ Route: _____

Frequency/Times to be given: _____Start Date: ___/___/___ Stop Date: ___/___/___

Reason for taking medication: _____

Potential side effects/adverse reactions: _____

Treatment in the event of a reaction: _____

SPECIAL INSTRUCTIONS: _____

Is this medication a controlled substance? YES or NO

Is this medication approved to be self-administered by the student? (inhaler, Epi-pen): YES or NO

I authorize the appointed representative from VHUMC to administer or assist my student in taking the above medication.

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

Medication Name:_____ Dosage:_____ Route: _____

Frequency/Times to be given: _____Start Date: ___/___/___ Stop Date: ___/___/___

Reason for taking medication: _____

Potential side effects/adverse reactions: _____

Treatment in the event of a reaction: _____

SPECIAL INSTRUCTIONS: _____

Is this medication a controlled substance? YES or NO

Is this medication approved to be self-administered by the student? (inhaler, Epi-pen): YES or NO

I authorize the appointed representative from VHUMC to administer or assist my student in taking the above medication.

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

PARENT AUTHORIZATION

I authorize the appointed representative from VHUMC to administer or assist my student in taking the above prescription medication in accordance with the Student Ministry Medication Policy and under the directed orders as prescribed by a doctor. **I understand that additional parent signed statements will be necessary if the dosage of medication has been changed.** I also authorize the VHUMC representative to talk with the prescriber or pharmacist should a question arise concerning the medication. Prescription medication must be kept in the original prescription bottle, properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate. Over-the-counter medications must be parent approved on the form above.

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

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider and it is in line with the Student Ministry Medication Policy.) I authorize and recommend self-medication by my student for the medication(s) listed below. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the church, the agents of the church, and the leadership of the church against any claims that may arise relating to my student's self-administration pf prescribed medications(s).

Medication(s) to be self-administered by student: _____

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