PARKS &COMMUNITY
CITY OF DRIPPING SPRINGS

Health/Medication Authorization Form

Complete this form for any individual with, medication (prescription/non-prescription), and/or emergency medical devices. This form must be completed fully. A new health/medication form must be completed at the beginning of each camp season, for each medication, and each time there is a change in dosage or distribution of medicine. Prescription medication must be in a container labeled by the pharmacist or prescriber. Non-prescription medication must be in the original container with the instructions for use. Non- prescription medication includes over-the-counter vitamins, homeopathic, and herbal medicines. An adult must bring the medication to camp and give the medication to the adult camp operator/camp staff on site. Program staff will verify in writing the type of medication, the dosage of the medication, when the medication needs to be administered, and the amount of medication dropped off (up to 1 program session).

I. General Information

Participants Name:

Program Name & Session(s):

II. Medication

Name of the medication:

Reason(s) for medication: Emergency Medication? ☐ Yes ☐ No

Medication Dose/Frequency:

Possible side effects of medication(s):

Physician Name & Title: Physician Phone Number:

III. Authorization for Self-Carry

This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medical devices such as inhalers or epinephrine. *I consent that the child named above is able to self-administer the medication listed. I authorize the self-administration of the above-listed medication for the child named above under the supervision of an authorized youth camp operator/staff member. If indicated below, the child named above may self-carry emergency medication. I agree to release the City of DrippingSprings and its agents from any and all liability arising as a result of this waiver.*

Printed Name (Parent/Guardian) Signature Date

IV. Parent/Guardian Authorization

I request the authorized youth camp operator/staff to supervise the camper in self-administration if authorized as prescribed by the above prescriber. I certify that I have legal authority toconsent to medical treatment for the child named above, including the distribution of medication at the facility. I understand that at the end of the authorized period, an adult must pick upthe medication; otherwise, it will be discarded within ONE WEEK of the camper leaving camp. I authorize camp personnel to communicate with the prescriber as allowed by HIPAA agree to release the City of Dripping Springs and its agents from any and all liability arising as a result of this waiver.

Printed Name (Parent/Guardian) Signature Date