Prescription Form - 1

AUBURN UNIVERSITY SUMMER ENGINEERING ENRICHMENT PROGRAM

MEDICATION PRESCRIBER/PARENT AUTHORIZATION

Program Name ______________ Summer Engineering Enrichment Program ________________________________________________

Date(s) ______________________ June 2-29, 2019 ______________________________________________________________

PARTICIPANT'S INFORMATION

Participant’s Name _______________________________________________________________________________________

Parent/Legal Guardian Name ______________________________________________________ Street Address __________________________________

City ______________________________ State _____________ Zip __________________ Home Phone ______________________

Work Phone _________________________ Cell Phone _________________ Email ___________________________________

Date of Birth ______/_______ /_______ Gender M              F

_____ No, my child does not need to take any prescription medication while at the Summer Engineering Enrichment Program.

_____ Yes, my child will need to take prescription medication while at the Summer Engineering Enrichment Program.

This form must be completed fully in order for a participant to administer required medication to themselves. A new medication administration form must be completed for each participant, for each medication, and each time there is a change in dosage or time of administration of a medication. Requires licensed health care authorization and signature, and parent signature.

- Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include the name, address and phone number for pharmacist or prescriber.
- Containers must hold only the amount required for the time the participant will be attending the Summer Engineering Enrichment Program.
- All prescription medications, including medications for conditions such as food, drug or insect allergies; diabetes; asthma; or epilepsy may be brought to the Summer Engineering Enrichment Program under the condition that the participant can self-manage care and delivery of medication with written authorization to do so at Academic Excellence Program by a licensed health care provider.

PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication Name  ____________________________________________       Dose  ___________________________________________________

Condition for which medication is being administered  ___________________________________________________________________________

Specific Directions (e.g., on empty stomach/with water, etc.)  _______________________________________________________________________

Time/frequency of administration  _________________________________________________________________________________________________

If PRN, frequency  _______________________________________________________________________________________________________

If PRN, for what symptoms  _________________________________________________________________________________________________

Relevant side effects  ______________________________________________________________________________________________________

Medication shall be administered from _______/_______/_______ to _______/_______/_______.

Special Storage Requirements:  ____________________________________________________________________________________________

Is the participant capable of self-managed care?                    Yes                              No

Prescriber’s Name/Title:  ______________________________________ Prescriber’s Place of Employment: ________________________________

Telephone: ___________________________________________________   Fax:  ______________________________________________________

I hereby affirm that this individual has been instructed in the proper self-administration of the prescribed medication(s).

Prescriber’s Signature: ________________________________________________  Date:  ____________________________________________
PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

I authorize and recommend self-medication by my child for the above medication. 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 Program Staff, Auburn University, its Board of Trustees, Administration, Faculty, Staff, Counselors, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my child’s self-administration of prescribed medication(s).

I/we have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the Summer Engineering Enrichment Program.

Parent/Guardian Signature ____________________________________________ Date ___________________________________

Home Phone # _______________________ Cell Phone # _____________________ Work Phone # _______________________

PARENT/GUARDIAN AUTHORIZATION, WAIVER AND CONSENT FOR OVER-THE-COUNTER MEDICATION

Over-the-Counter (OTC) Medication may at times need to be administered, if approval is indicated by the participant’s parent or guardian. Please complete the following section to save time if your child needs any of these OTC medications during his/her stay. Note: Unless we have parental authorization, we cannot administer ANY medications.

I hereby authorize that the following medications may be given to ______________________________________ (Child’s Name) if the need arises. You may dispense only those checked.

- Ointments for minor wound care, first aid as directed. (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
- Tylenol/Acetaminophen as directed.
- Aspirin/Ibuprofen as directed.
- Throat lozenges and or spray as directed for sore throat.
- Micatin or anti-fungus treatment as directed for athlete’s foot.
- Kapectate or Imodium for diarrhea as directed.
- Milk of Magnesia, Pepto Bismol or Mylanta for upset stomach or nausea as directed.
- Rolaids or Tums for acid reflux, heartburn or indigestion as directed.
- Benadryl for swelling, hives, allergic reaction, as directed.
- Actifed or Sudafed as directed for nasal congestion or allergy relief per instructions.
- Visine or other eye drops for minor eye irritation.
- Medicated lip ointment for dry, chapped lips, lip blisters or canker sores as directed.
- Swimmer’s ear drops as directed.
- Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites.
- Medicated powder for skin irritation as directed.
- Robitussin or other cough syrup as directed.
- Calamine lotion for bug bites and poison ivy.
- Sunscreen
- Bug repellent
- Other (list any other approved over-the-counter drugs)

Program staff reserves the right to use generic equivalents when available for the name brand over-the-counter medications listed above.

I understand that such administration will not be done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed.

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined treatment will be followed-up by a consultation with the participant’s parents. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked.

I understand that these over-the-counter medications are not necessarily kept on hand and available to be administered immediately.

I authorize the administration of over-the-counter medications to my child as indicated above. I shall indemnify and hold harmless the Program Staff, Auburn University, its Board of Trustees, Administration, Faculty, Staff, Counselors, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my child being administered the above indicated over-the-counter medications.

I/we have legal authority to consent to medical treatment for the participant named above, including the administration of medication at the Summer Engineering Enrichment Program.

Parent/Guardian Signature ____________________________________________ Date ___________________________________

Home Phone # _______________________ Cell Phone # _____________________ Work Phone # _______________________

Prescription Form - 2