St. Patrick Youth Community

PHYSICIAN'S REQUEST FOR SELF-ADMINSTRATION OF MEDICATION IN CAMP/YOUTH

STUDENT'S NAME_____

ADDRESS_____

MEDICATION_____

DOSAGE_____**FREQUENCY & DURATION**_____

DOES MEDICATION REQUIRE REFRIGERATION?_____

POSSIBLE SIDE EFFECTS, IF ANY_____

1. This patient/student has been given detailed instructions in self-administration of this medication.
2. This patient/student is cognizant of his/her actions and is capable of self-adminsitration.
3. This medication lends itself to self-administration.

_____ _____

Date Physician's Signature & Stamp

Phone _____

PARENTAL CONSENT FOR SELF-ADMINISTRATION OF MEDICATION

1. We give Camp St. Patrick/St. Patrick's Youth permission to allow our child, _____ to self-administer the medication, _____ in the presence of an adult supervisor.

2. He/she has been instructed as to the proper administration of this medication. He/she is cognizant of his/her actions and is capable of self-administration.

3. We, hereby, release Camp St. Patrick/St. Patrick's Youth from liability in connection with the self-administration of this medication by the student in the absence of a nurse.

Parent/Guardian Signature_____ _____