If your child requires any medication (prescription or non-prescription) while s/he is attending the above-mentioned program, you must complete and sign this form. We will store the medication for your child to self-administer and, at the start of the program, will advise your child where s/he can obtain his/her medication.

For safety reasons, medications must be in their original container, which clearly identifies the child, the medication, dosage, prescribing physician, and written instructions for administering the medication. We will not accept more than one week’s worth of medication at any given time.

I, ______________________________ (parent’s name), am the parent or guardian of ________________ (child’s name).

I give permission for my child to receive the below listed medication during camp hours. Whenever possible, parents should schedule the times their child receives medication in such a way that the child does not need medication during class times.

I understand that UWM does not have the resources available to administer prescription or non-prescription medication. I have determined that my child is capable of taking his/her own medication and I have prepared my child to self-medicate. If my child is unable to self-medicate, I understand that I must arrange to have an adult available to administer the medication during the program.

I will make arrangements, as needed, to remind my child to take his/her medication. I understand that program staff are not responsible for reminding my child to take his/her medication.

If the medication is an inhaler or Epi-pen, I request that my child be permitted to carry it with him/her and agree that my child is capable of administering the medication as needed. If my child is not capable of self-administering this medication, I understand that I must make arrangement to have an adult remain with my child for the duration of the program.

Name of Medication: ____________________________________________________________

Dosage: ______________________________________________________________________

Form: ______________________________________________________________________

Approximate Time to Be Taken: ________________________________________________

Possible Side Effects: _______________________________________________________

Physician Name/ Contact Information: __________________________________________

Dates during which medication needs to be taken: ________________________________

My child needs to carry the medication with him/her for emergency purposes: Yes or No (circle one)

I agree and acknowledge that UWM is not responsible for the use, misuse, theft, or loss of my child’s medication.

Signature (Legal Guardian) ________________________________ Date: ______________

Name (Legal Guardian) ___________________________________________ Daytime Phone __________________