GEORGIA COLLEGE
GEORGIA'S PUBLIC LIBERAL ARTS UNIVERSITY

231 W. Hancock St
Milledgeville, GA 31061-0490
Phone Number: (_____) _____-______
Fax Number: (_____) _____-______

GC Youth Programs
Authorization to Administer Medication/Medication Listing

Child's Name: ____ Age: _________ Weight: _________ Height: __________

Address: ____ City: ____________________ State: __________

Parent/Guardian Name: ____

Home Phone: _________________________ Cell Phone: ______________________ Work Phone: __________________

I hereby authorize the program staff to administer the listed medication(s). I understand that only oral prescription medication will be administered unless authorized by the Program Administrator. Medications must be brought in by the parent and should be kept in original containers which includes the pharmacy label, date of filling, pharmacy name and address, patient name, name of prescribing practitioner, name of prescribed medication, directions for use and cautionary statements, as well as expiration date. Expired medication will not be accepted. When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

By signing this form, I hereby acknowledge that all information is accurate and current, that all pertinent and important medication information is listed on this form, and to the best of my knowledge, my child can participate safely in the program. I acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this program. I agree to notify the program of any changes in this information in a timely and reasonable manner.

I hold harmless and agree to indemnify the program and Georgia College & State University, as well as the Board of Regents, from any claims, causes of action, damages, and/or liabilities arising out of or resulting from said medical treatment.

Statement to Self-Administer

Georgia College realizes that EpiPens and Inhalers are emergency medications. Georgia College staff will gladly keep this medication for the duration of the program. However, if you would like to authorize your child to keep these medications during the program, please initial below.

☐ INITIAL — My child requires the use of an EpiPen for severe allergic reactions. I hereby authorize Georgia College to allow my child to keep this EpiPen on his or her person for the duration of the program.

☐ INITIAL — My child requires the use of an inhaler. I hereby authorize Georgia College to allow my child to keep an inhaler on his or her person for the duration of the program.

Parent or Guardian Name: ______________________________ Date: ____

Signature of Parent or Guardian: ________________________

Parent/Guardian Meeting Notes

Date of meeting: ______________________ Time of meeting: _______________________________

Attendees:

Notes:

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Medication Listing

Child's Name: ____________________________________ Parent/Guardian Name: _______________________________

Name of Medication: ____

Prescription Number: ____

Name of Licensed Prescriber: ____

Instructions:

Special Storage Instructions:

Dates to Administer	Times to Administer	Amount (Dosage)	Official Use Only: Completed by Georgia College		
			Time Administered	Administered by	Adverse Reactions