

# CONSENT FOR MEDICATION ADMINISTRATION

Activity/Camp: \_\_\_\_\_

Date(s): \_\_\_\_\_

## PARENTS OF PARTICIPANTS UNDER AGE 14

If your son/daughter/ward will be under the age of 14 while with the University of Wisconsin – Whitewater, it is the State of Wisconsin Department of Health and Family Services policy that we collect, secure and administer any prescription medication brought to an activity. Exceptions are only for a limited amount of medication for life-threatening conditions (e.g. bee sting, medication inhaler). Non prescription medications or devices may be carried by the participant provided the Medication Consent Form has been signed by a parent or guardian. Please complete the following:

\_\_\_\_\_ **No medication** will be/has been brought to the activity/camp

\_\_\_\_\_ My son/daughter/ward will bring/has brought the following **non-prescription medication** to the activity/camp and has our permission to **self-administer**.

**Name of Medicine:** \_\_\_\_\_

\_\_\_\_\_ My son/daughter/ward will bring/has brought the following **emergency medication** (i.e. bee sting kit, inhaler) to the activity/camp and has our permission to **self-administer**. **Please complete the following:**

_____	_____	_____	_____
Name of Medicine	Prescribing Doctor	Doctor's Phone	How is it taken?

_____	_____	_____	_____
Amount to be taken	Days to be taken	Time(s) of day	Special Instructions

\_\_\_\_\_ My son/daughter/ward will bring/has brought the following **non-emergency prescription medication** to the activity. I understand it must be collected, secured, and **administered by staff**. **Please complete the following:**

_____	_____	_____	_____
Name of Medicine	Prescribing Doctor	Doctor's Phone	How is it taken?

_____	_____	_____	_____
Amount to be taken	Days to be taken	Time(s) of day	Special Instructions

## PARENTS OF PARTICIPANTS AGE 14-18

If your son/daughter/ward will be between the ages of 14-18 while with the University of Wisconsin – Whitewater, it is the State of Wisconsin Department of Health and Family Services policy that we secure your consent regarding the dispensing of prescribed medication and for the use of medical devices. Please complete the following:

\_\_\_\_\_ **No medication** will be/has been brought to the activity/camp

\_\_\_\_\_ I give permission for the **prescription medication** or medical devices to be **self-administered** by my son/daughter/ward. S/he has brought the following medication to the activity/camp:

_____	_____	_____	_____
Name of Medicine	Prescribing Doctor	Doctor's Phone	How is it taken?

_____	_____	_____	_____
Amount to be taken	Days to be taken	Time(s) of day	Special Instructions

\_\_\_\_\_ I request that the **prescription medication** or medical devices be collected, secured, and **administered by the staff**. Please complete the following:

_____	_____	_____	_____
Name of Medicine	Prescribing Doctor	Doctor's Phone	How is it taken?

_____	_____	_____	_____
Amount to be taken	Days to be taken	Time(s) of day	Special Instructions



\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date