OUT-OF-SCHOOL TIME PROGRAMS MEDICATION CONSENT FORM

Please ensure all sections of this form is completed accurately and fully. Incomplete and/or out dated forms will delay the approval process. One form is required per medication, per program registration period.

1) Parent/Legal Guardian ***MUST*** complete ***#1-#7 and #15. #8-#14 MUST*** be completed for medication to be administered 10 days or less, non-prescription or topical medications, or submitting alternate consent forms such as Hampton Roads School Medication, Life Threatening Allergy Management Plan (LAMP) or Virginia Asthma Action Plan.
2) Licensed Authorized Prescriber ***MUST*** complete ***#8-#14, #17 (if applicable) and #18-#21***
3) If your child requires an Epinephrine Injector, you ***MUST*** complete this form **AND** our Consent for the Administration of Epinephrine Injections Form
4) Submit completed forms at least 2-weeks before your child will begin. The Medication Manager will contact you once they have received and approved your forms.

PARENT/LEGAL GUARDIAN INFORMATION

1. FIRST & LAST NAME	2. PRIMARY PHONE	3. DATE COMPLETED

PARTICIPANT INFORMATION

4. FIRST & LAST NAME	5. DATE OF BIRTH	6. PROGRAM *(CHECK ONE)* □ SCHOOL YEAR □ SUMMER	7. ALLERGIES

MEDICATION INFORMATION

8. NAME OF MEDICATION INCLUDING STRENGTH	9. AMOUNT/DOSAGE TO BE GIVEN	10. ROUTE OF ADMINISTRATION

11. FREQUENCY TO ADMINISTER OR SPECIFIC TIME	12. IDENTIFY SYMPTOMS THAT WILL NECESSITATE ADMINISTRATION

13. POSSIBLE SIDE EFFECTS *(PARENT MUST SUPPLY PACKAGE INSERT)*	14. DATE TO BE DISCONTINUED OR LENGTH OF TIME IN DAYS TO BE GIVEN *(CANNOT EXCEED 12 MONTHS)*

PARENT ACKNOWLEDGMENT AND RELEASE

I will not hold the City of Virginia Beach, Virginia Beach Department of Parks and Recreation and its, Out-of-School Time Programs unit or any of its employees, contractors or agents liable for any negative outcome resulting from the self-administration of medication approved on this form by the participant.

I understand that the Virginia Beach Department of Parks and Recreation, Out-of-School Time Programs unit, after consultation with the parent(s) may impose reasonable limitations or restrictions upon a participant's possession and/or self-administration of said medication relative to the age and maturity of the participant and other relevant consideration.

I understand that the Virginia Beach Department of Parks and Recreation, Out-of-School Time Programs unit, may withdraw permission to carry and self-administer medication at any point during the duration of the program if it is determined the participant has abused the privilege of carrying and self-administration or that the participant is not safely and effectively administering the medication.

I have read and fully understand the procedures and guidelines set forth in the Out-of-School Time Programs Medication Policy.

I have read and fully understand these guidelines. I voluntarily consent to the program maintaining the medication listed herein and to my child self-administering said medication(s). I further agree to adhere to the above guidelines.

15. PARENT/LEGAL GUARDIAN SIGNATURE DATE

16. PARTICIPANT SIGNATURE *(FOR SELF-CARRY AND/OR SELF-ADMINISTER REQUEST)* DATE

LICENSED AUTHORIZED PRESCRIBER INFORMATION

17. PERMISSION TO CARRY AND/OR SELF-ADMINISTER LIFE SAVING MEDICATION

This section is to be completed if a participant has a life-threatening medical condition and the healthcare provider, parent and participant agree the participant is mature and able to carry the medication and/or self-administer as needed.

Licensed Prescriber please check all that apply:

□ I as the Healthcare Provider, certify that this child has a medical history of asthma and has been trained in the use of the prescribed medication(s). Staff on Duty and an OST Supervisor should be notified anytime the medication is used. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

□ I as the Healthcare Provider, certify that this child has a medical history of severe allergic reactions and has been trained in the use of the Epi-Pen. Staff on Duty and an OST Supervisor should be notified anytime the injector is used. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

□ Self-Carry □ Self-Administer

18. LICENSED PRESCRIBERS PRINTED NAME	19. LICENSED PRESCRIBERS SIGNATURE	20. LICENSED PRESCRIBERS TELEPHONE	21. DATE AUTHORIZED

OUT-OF-SCHOOL TIME PROGRAM MEDICATION MANAGER INFORMATION

22. DATE RECEIVED	23. DATE PROCESSED	24. PROGRAM NAME & LOCATION

25. DECISION □ APPROVED □ PENDING □ DENIED	26. REASON (IF PENDING/DENIED INDICATED)

27. PARENT CONTACTED (DATE, TIME, METHOD)	28. DATE ENTERED INTO MEDICATION SPREADSHEET	29. DATE MEDICATION LOG CREATED

30. MEDICATION MANAGER PRINTED NAME	31. MEDICATION MANAGER SIGNATURE

Revised 3/17/2020