



Fairfax County Park Authority Medication Authorization Form



This form must be completed in English. One form for each medication is required. FCPA strongly suggests *all* medication be administered at home. Any new medication must be administered at home first.

- Parents must complete #1-23 for all medication being administered at camp
- A licensed prescriber/physician's signature is required for ALL prescribed medications

PARENT/GUARDIAN OR PHYSICIAN TO COMPLETE (see instructions above)

1. Child's first and last name		2. Date of Birth	3. Child's Known Allergies
4. Name of Medication (including strength)		5. Dosage Amount to be Given	6. Route of Administration
7. Frequency to be administered (times per day or specific times) or identify symptoms that will necessitate administration of medication (signs and symptoms must be observable and when possible, measurable):			
8. Possible side effects:			
9. Action to be taken if side effects are noted (circle one): contact parent OR contact prescriber OR Other (describe):			
10. Special Instructions:			
11. Reason child is taking the medication (unless confidential by law):			
12. Does this child have a chronic physical, developmental, behavioral or emotional condition expected to last more than 12 months and requires health related services beyond what is normally required for children? _____ If yes, complete #24-#25.			
13. Are the instructions on this consent form a change in previous medication order (or different from medication label) as it relates to dose, time or frequency to be administered? _____ If yes, complete #26-#27.			
14. Date to be discontinued or length of time (days) to be given:		15. Prescriber's Name:	
		16. Prescriber's Phone Number:	
17. Licensed Prescriber/Physician's Signature: required for all prescribed medications			18. Date Form Completed:

This is a two-page form

Child's First and Last Name: _____

PARENT/GUARDIAN MUST COMPLETE (#19-#23)

19. Are there clear instructions provided for frequency to be administered in #7? If not, specify times the medication is to be administered? _____, _____, _____

20. I, parent/guardian of _____ (child's name), hereby authorize Fairfax County Park Authority (FCPA) personnel to administer medication to my child as directed on this form. I agree to release, indemnify, and hold harmless FCPA and any of its officers, staff, volunteers, contractors or agents from lawsuit, claims, expense, demand, or action against them for administering medication to my child. I am aware medication will be administered by a specifically trained non-health professional. For Epi-pens: Emergency injections are administered by non-health professionals who are taught by the Fairfax County Health Department. For this reason, only pre-measured doses of Epinephrine may be given. It should be noted that these staff members are not trained observers; therefore, they cannot observe for the development of symptoms before administering the injection. I understand that the rescue squad will always be called when Epinephrine is injected, whether or not the child manifests any symptoms of anaphylaxis.

21. Parent or Legal Guardian's Name (please print): _____

22. **Parent/Guardian's Signature:** _____

23. Date Authorized: _____

LICENSED PRESCRIBER TO COMPLETE AS RELATED TO #12 and #13

24. Describe any additional training procedures the child day program staff will need to care for this child: _____

25. **Licensed Prescriber's Signature:** _____

26. There may be instances where the pharmacy will not fill a new prescription for changes related to dose or frequency until the current order of medication is completely used. Please indicate the date by which you expect the pharmacy to fill an updated order. DATE: _____

27. **Licensed Prescriber's Signature:** _____

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

Site/Location: _____

Telephone #: _____

I have verified this authorization form is complete. My signature indicates that all information needed to give this medication has been given to the program.

FCPA Representative/Employee's Name (Please print): _____

FCPA Representative/Employee's Signature

Date Form Received